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CATASTROPHIC HEALTH INSURANCE

HEARING

BEFORE THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

S. 210

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO PROVIDE CATASTROPHIC HEALTH INSURANCE COVERAGE FOR ELDERLY AND DISABLED AMERICANS

APRIL 8, 1987

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CATASTROPHIC HEALTH INSURANCE

WEDNESDAY, APRIL 8, 1987

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Hatch, Adams, Weicker, Thurmond, Mikulski, Harkin, Quayle, and Cochran.

Also present: Senator Sasser and Representative Claude Pepper.

OPENNING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We will come to order.

This hearing deals with one of the most important issues facing the 100th Congress. In my judgment, there is no social problem more compelling than the need to protect our senior citizens against the high costs of essential health care.

When I came to the Senate in 1963, Congress was in the final stage of the long and successful battle to insure elderly Americans against the intolerable financial burden of serious illness. President Kennedy was proud of his role as the first President to propose Medicare. And Medicare did make a huge difference in the security and health of our senior citizens.

But because of gaps in Medicare coverage and the lack of a catastrophic "stop-loss" protection, our Nation's senior citizens are still far too often at risk for the loss of a life-time of savings and the promise of a secure and dignified retirement when serious illness strikes. Indeed, Medicare today covers less than $4,420. An individual with a four-month stay will have costs of over $12,000. If that same individual has previously used up his life-time reserve days, the cost of a four-month hospital stay would be a staggering $20,000. And this total is just for hospital costs: out-of-pocket expenditures for physicians services associated with the hospital stay are additional.

Medicare's coverage for physician service has gaps as serious as its coverage of hospital costs. After an initial deductible of $75 is paid, Medicare covers 80 percent of recognized charges by physicians. This percentage is comparable to many excellent private insurance plans, but, unlike the better private plans, there is no limit on how high the beneficiary's 20 percent can mount. Moreover, many physicians charge more than Medicare's recognized charges, and these excess charges are the sole responsibility of the beneficiary.

Just as senior citizens are responsible for many costs for services that Medicare supposedly covers, there are some essential services that Medicare does not cover at all. Medicare provides not protection whatever against the potentially high cost of essential outpatient prescription drugs. Medicare's benefit for putpatient mental health and substance abuse treatment is so half of the elderly's health care costs. On average, our senior citizens must pay the same high proportion of their limited incomes—15 per cent—to purchase the health care that they need as they did before Medicare was even created.

Let me review the key gaps in Medicare's acute care benefit package.

Medicare charges a high deductible for the first day of a hospital stay. This deductible is now a staggering $520, and would be even higher except for reforms that I introduced that were adopted in the 99th Congress. Approximately eight million Medicare beneficiaries—more than one out of every four—must pay this deductible each year, and over a million pay it more than once.

Medicare enrollees are also vulnerable to the extraordinarily high costs of very long hospital stays. After 60 days of care in a spell of illness, Medicare beneficiaries are responsible for a co-payment of $130 per day. After 90 days of care, Medicare coverage ends except for 60 lifetime reserve days which carry a co-payment of $260 per day. Thus, a senior citizen with a three-month hospital stay will have incurred costs of limited as to be essentially meaningless—despite a significant incidence of these problems among the elderly. And Medicare does not cover the cost-effective preventive health care that could avert unnecessary illness among enrollees. And of course, Medicare provides only very limited coverage for nursing home and home health care.

Many senior citizens buy private Medigap policies that fill some of the holes in Medicare coverage. Other senior citizens are covered by Medicaid. But 20 percent of all senior citizens cannot afford Medigap and do not qualify for Medicaid. These senior citizens are not only extremely vulnerable to high health care costs, they also have much less access to needed medical care because of their inability to pay. Thus, as the Congressional Budget Office pointed out in a recent study, senior citizens without Medigap coverage use significantly less health care services than those with Medigap, even though seniors who have Medigap coverage are younger and healthier than those without supplementary protection.

Even those senior citizens who are able to afford and purchase private Medigap are not getting the economical health care insurance protection they deserve. Few Medigap policies cover outpatient drugs or mental health care. Many policies do not fully cover the cost of very long hospital stays. Virtually none cover long-term care. And, depending on the policy the senior citizen purchases, between ten and forty percent of every premium dollar buys no additional protection whatever. Instead, it is invested in sales, marketing and administrative expenses, and profit. By contrast, only a few cents of each Medicare dollar must be used to pay for administration rather than health services.

Secretary Bowen has proposed an innovative plan that has elevated this issue to the top of the national policy agenda. He is to be congratulated for this effort and for sticking with his proposal in the face of often vituperative opposition.

The Bowen plan, however, is actually not a complete solution to the problem of catastrophic costs faced by the elderly. Most seniors experiencing catastrophic out-of-pocket costs will not be protected adequately by the Bowen plan. Because they are low-income, their out-of-pocket expenses generally reach a catastrophic level before they reach the $2,000 cap. Almost half of all the costs experienced by those who reach a catastrophic level of expenditures, even excluding long-term care, are incurred for services that are not covered by Medicare—especially outpatient prescription drugs. Adoption of the Bowen plan as introduced will not prevent pauperization of spouses of seniors who must enter a nursing home, and will not improve the access of low-income seniors to essential care.

I think it is the obligation of the Congress to pass not only the Bowen plan but also a number of high priority improvements to it. The chance to begin to finally fulfill the promise of Medicare may not come again soon, and we in the Congress would be derelict in our responsibilities if we did not want the best possible protection for our senior citizens this year.

I am hopful that our hearing today will help us identify the steps that are most urgent.

The Senator from Utah, Senator Hatch, who has been very interested in long-term care and has introduced legislation on that issue, and who I know is very concerned about this question as well.

Senator Hatch.

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Senator Kennedy.

I am happy to welcome the witnesses here. I am certainly pleased to have you, Senator Sasser, and you, Congressman Pepper, and look forward to the Secretary of Health and Human Services, Dr. Otis Bowen, being with us today.

Today's hearing is an important hearing. I think no issue is more at the center of our deliberations than catastrophic health care protection and long-term care, as Senator Kennedy has articulated. The fundamental question which we in Congress must decide is what kind of care and assistance should be offered and in what type of offering or setting should that care be provided.

I am pleased to join with Senator Kennedy at today's hearings, highlighting catastrophic health care needs of our Nation's senior citizens. Our elderly in American suffer from catastrophic illness. Roughly 4 million elderly Americans suffer from chronic heart or lung conditions, and many seniors have severe problems because of stroke, and up to 4 million Americans will suffer from Alzheimer's Disease alone. A total of 9 million elderly suffer from catastrophic illness, and 4 million just from Alzheimer's Disease.

Examples of financial ruin caused by catastrophic health care costs are not very hard to find. Today, we will learn from Mrs. Cleo Bowyer of our own home State of Utah about her husband, a victim of Alzheimer's Disease and their struggles to pay his rising health care bills.

President Reagan called on Dr. Bowen to report on ways to finance both public and private sector ways to address the problem of catastrophic health care costs. I have to say that I believe Dr. Bowen accepted that challenge and has tried to do the best that he can. And he has prepared a proposal that have brought this issue the attention it deserves, and I want to commend him for the work and effort that he and his staff have done.

I do urge Dr. Bowen and all of my colleagues in the Senate that before we become too preoccupied with the specific details of the Bowen plan, we must first resolve whether the best solutions to the costs of catastrophic illness lie in Government or private sector financing. I believe the answer probably lies in a combination of both of them.

We must foster our commitment to ensure the financial viability of the Medicare program. It is the cornerstone in providing elderly citizens with health care. We must develop a broad program that urges the private sector to reduce the financial woes that result when a catastrophic illness hits any particular family. And we have to support the role of the States in formulating health care policy for the low-income citizens through the Medicaid program. And most importantly, we must provide Americans with an alternative to institutionalization for those who can be cared for in their own homes.

So I hope Dr. Bowen will be able to help us on this. My folks in Utah will not be happy anywhere else but in their own home. That is where they will be the happiest. And I have hundreds of letters from them. They want a catastrophic health care proposal that encourages the delivery of home care.

Since 1978, Utahans have joined me in advocating for increased home health care services, and this year, I intend to again join the charge. I want the Committee's help, Dr. Bowen's help, Louise Crooks' help as representative of the American Association of Retired Persons; Congressman Pepper, I know you have been strongly working on this with us; and Dr. Brickner, who has been one of the guiding lights in this country, and others—I hope you will all work with me on a new approach to providing health care within the home.

I have a draft of the bill and a description of its purposes, and my suggestion is that we pay for a team of health care professionals to provide care within a person's home. Let them develop an appropriate treatment plan. Let them work on providing quality health care services in a cost-effective way. I truly believe that this approach will be a catalyst in demonstrating effective long-term care services.

One example of cost savings for home health service can be found in a Utah program called "Alternatives". It focuses on persons applying for nursing home admissions for nonmedical reasons and has achieved a 25 percent reduction in State expenditures for nursing home care. Cost per client day in 1978 and 1979 was about $8 compared to costs of $24 to $33 for daily nursing home care. And Blue Cross-Blue Shield of Maryland reported a savings of $1.2 million in 1982 from that State's coordinate home health care program.

Now, since 1973, they reported a net savings of $6.3 million. So I contend that home care is effective, and we will get into the chart over here when Dr. Bowen testifies.

Now, even more importantly, a recent poll asked the American public what setting they would like to see expanded for health care delivery. The result was a resounding victory for home health care. Americans, by a margin of nine to one, prefer home care to institutional care.

So I look forward to working with my colleagues on the Committee, and with Secretary Bowen as well and the others I have mentioned on this new legislation. We have to build a strong bipartisan coalition to craft a workable solution that continues our families' and our neighborhoods' access to the most advanced, beneficial health care system found anywhere in the world today.

I want to thank you, Mr. Chairman, for holding these hearings. They are crucial hearings. They are hearings that will make a difference, I believe, in the lives of millions of people, and I personally appreciate your leadership in this area.

The Chairman. Thank you very much.

The Senator from Washington, Senator Adams.

OPENING STATEMENT OF SENATOR ADAMS

Senator Adams. Thank you, Mr. Chairman.

I want to welcome all of the witnesses here this morning. The witness list bears testimony to the importance of this subject to the Nation and certainly to this Committee. And this morning, I want to particularly welcome the Honorable Claude Pepper, who is from the House of Representatives, but who I first met in Washington, D.C. when he was a member of the United States Senate.

Welcome, Senator Pepper. We are pleased to have you as a witness this morning.

And Senator Sasser, we are so pleased that you could join us this morning. Your work in this area is well-known, and we are looking forward to your testimony.

Mr. Chairman, before hearing from these witnesses, including the Honorable Otis Bowen, the Secretary, who I think should be congratulated for his efforts in this area and for his initiative in catastrophic health care, I would like to make several observations.

First, to me it is clear that it is time to protect the elderly against the high costs of medical care. Medicare was enacted in recognition of the fact that the elderly simply could not afford the cost of medical care. Yet today, the average out-of-pocket cost for health care by the elderly is the same as it was then—15 percent of their income.

While the health of our senior citizens and our older population has clearly improved, their ability to absorb the cost of medical care has not. We must act boldly and swiftly to remedy this situation.

Second, I applaud the effort of those who have taken an initiative in shaping a proposal to broaden the benefits available to Medicare beneficiaries, particularly in the event of catastrophic illness. Under the existing scheme of copayments and deductibles, a prolonged hospital stay can spell financial ruin.

However, it is important to keep in mind that the cost of acute care is only one of the many costs the elderly must absorb. As the Chairman pointed out so very well on the charts, the largest out-of-pocket costs for 75 percent of our senior citizens is the cost of prescription drugs.

We also do not cover many of the cost-effective preventive health care measures which avert unnecessary illness and can provide our seniors with a meaningful and worthwhile life.

Third, it is evident that our system of hospital reimbursement is forcing hospitals to discharge Medicare patients when they are still in need of ongoing care. While these patients do not necessarily need the type of intensive care provided in an acute care facility, they certainly are not able to care for themselves. Unfortunately, Medicare offers only limited transitional care benefits, forcing many to go without care. Congress must consider expanding coverage for home health care and other effective means of providing transitional care for our senior citizens.

Finally, it is clear to me that this Nation needs to address the subject of long-term care for the chronically ill. No subject weighs more heavily on the minds of the elderly than the costs associated with long-term care. I have had personal experience with both home care of my relatives and of nursing home care involving both Alzheimer's and chronic illness, which lasted for long periods of time.

For a person of average means, admission to a nursing home is often the first step on the road to poverty. Many people shy away from discussing this issue because of the costs involved.

However, I do not believe that in good conscience we can continue to ignore the plight of the elderly, who have given so much to so many.

Mr. Chairman, I am pleased to join with you and the others to have an opportunity to air these concerns, and I look forward to hearing the testimony from the distinguished witnesses, and I am very grateful that the Chairman has started these hearings today.

The CHAIRMAN. Thank you very much.

The Senator from Connecticut, Senator Weicker.

OPENING STATEMENT OF SENATOR WEICKER

Senator WEICKER. Thank you very much, Senator Kennedy.

I want to first thank you for bringing us to this particular day of hearings. It has been a long road. You and I have worked long and hard, way back when, on the subject of health insurance for all Americans. And then I have to point out that it was Senator Ribicoff that, falling short of complete health care for all Americans, had suggested that at least we address the issue of catastrophic health insurance; it was one of the last things that Senator Ribicoff did before he left the United States Senate.

The point that I wish to make here, really, is that the matter of catastrophic health insurance, at least in this Senator's opinion, is only a compromise as to what we should be doing in its entirety.

And as such, I certainly hope we do not have an elongated deliberation whether in Committee or on the Senate Floor on a compromise. Catastrophic health insurance is something that should be enacted and should be enacted now.

I also want to touch upon just for one minute the comments made by my good friend Brock Adams of Washington, who also suggested that the issue of long-term health care is something that ought to be addressed.

The reference that he used was to the elderly of this Nation, and nobody will argue with that. But I also want to point out, even though it will not be a subject for this hearing, that I feel very strongly about the matter of catastrophic health insurance for the young of this Nation.

We have a situation of probably not many in the way of numbers. Believe me, the costs that are involved are staggering even to the point where parents have to get divorced in order to go ahead and be eligible under Medicaid for the cost of those young people who are either in wheelchairs or in beds for their lives—some, even from the time of birth. Believe me, that is catastrophic also. And for a Nation that wishes to take care of its elderly, may I suggest also that we have always invested in our young people. I am not going to dilute the importance or the direction of this hearing by spending further time on it, but it is something I intend to introduce before the Congress of the United States this year.

So Mr. Chairman, again, thank you for making possible the passage of legislation such as this in this session of the Congress. Like you, I have been frustrated over the past several years that we have not addressed this, and I am delighted that you have raised the matter, that you have given an opportunity for passage, but I am also grateful that Secretary Bowen has gone ahead and carried the ball within the Administration. I fully intend to support both the efforts of the Committee and the efforts of the Secretary.

The Chairman. Thank you, Senator Weicker.

I might just recall, since you mentioned the needs particularly of children, a hearing that we had a number of years ago where we were listening to some parents with children who had some very special needs, and as the Senator from Connecticut pointed out, under our system we were requiring bankruptcy of those parents in order that the children could in some instances be institutionalized. In our neighboring country of Canada, they encourage parents to take children out of institutions, and a number of families have taken children out of institutions, and they have arranged a financing system where they offset the medical bills so that many of these children are growing up with other children in a family setting, in a home. That family is not personally financially liable with that kind of an additional burden.

And I thought for a society that puts emphasis on family and stresses the importance of children an interesting lesson to learn. So we will look forward to the Senator's recommendations in this area.

Does the Senator from South Carolina want to make a statement?

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Thank you, Mr. Chairman.

Mr. Chairman, I want to commend you for conducting hearings on issues concerning catastrophic illness. Many of us know family, friends or neighbors who have suffered a devastating acute care illness that has destroyed their financial security. Such an illness requires treatment so costly that families can only pay for it by impoverishing themselves.

A catastrophic illness is financially devastating and requires personal sacrifices that can haunt families for the rest of their lives.

Elderly Americans require more medical care than younger persons. Average health care spending for an elderly person in 1984 was $4,200, compared to $1,100 for a person under 65.

Virtually all of the elderly have acute care insurance protection under Medicare. About two-thirds also have private supplementary insurance, or Medigap. However, these two types of insurance together still have some significant limitations in coverage. As a result, unpredictable health care expenses loom large in the personal budgets of the elderly.

There are gaps in Medicare as currently structured for acute care expenses. Hospital coverage is limited. After 60 days of hospital care, a Medicare patient begins to make increasingly costly payments, rising from $130 per day for days 61 through 90, to $260 per day for days 91 through 150, to the full cost of care for more than 150 days in the hospital.

On top of this, there is a required 20 percent copayment for all physician services covered by Medicare. The Medicare Program then requires the greatest payment from those with the most serious health problems.

President Reagan is to be commended for calling attention to this serious problem and for his efforts toward reaching a fiscally responsible solution.

Mr. Chairman, at this time, I also wish to commend Secretary Bowen for the important contributions he has made in seeking solutions to this problem. I have been impressed with the fine leadership Secretary Bowen has provided the Department of Health and Human Services.

Mr. Secretary, we are pleased to have you here today.

Mr. Chairman, while my schedule may not permit you to stay for the entire hearing, I look forward to reviewing the testimony of the witnesses today and again commend you for holding these hearings.

The CHAIRMAN. Thank you very much.

At this point I will insert in the record the opening statements of Senators Harkin, Quayle, and Humphrey and the prepared statement of Senator Cochran.

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. I would like to take just a moment to commend my colleague from Massachusetts for his leadership in articulating a national health policy agenda for the 100th congressional session, and for arranging this very important hearing today.

I would like also to raise an issue I know is of great concern to the chairman as well: That is the difficulties faced by over 36 million disabled Americans in obtaining even minimum insurance coverage. These people face, in a much exacerbated way, the access, affordability, and coverage concerns being articulated at this hearing today.

Most of them would be counted among the overall uninsured and underinsured population. In addition, people with disabilities are three times more likely to be in poverty; they are significantly represented among the chronically unemployed with 62 percent of people with handicaps aged 16 to 64 not in the labor force; and most fall through many of the presumed health care safety nets structured at the State and Federal levels.

For those with developmental disabilities who may have access to private coverage through family members, pre-existing condition exclusion clauses pose barriers to effective care. Those relatively few individuals who finally access private coverage often find that their disability-related health care needs are inadequately covered. Usually this is a reflection of the serious limitation in the benefit packages available in the lower paying service sector jobs people with handicaps are likely to hold.

Mr. Chairman, I know that this is not news to you. I only wanted to raise the issue to indicate my support for the catastrophic legislation, and my hope that we keep in mind those individuals—younger persons and disabled persons not covered by medicare—who fall outside of the scope of current catastrophic proposals. Thank you, Mr. Chairman.

OPENING STATEMENT OF SENATOR QUAYLE

Senator Quayle. Mr. Chairman, we all know that the President's catastrophic health insurance plan is controversial.

In fact, it's drawn criticism from all quarters almost from the moment by good friend—Health and Human Services Secretary Doc Bowen—first proposed the basic idea.

The administration's proposal has been attacked on the left because it doesn't cover the general population or long-term nursing home care.

It's been atacked on the right because it expands medicare and reverses some of the private-sector initiatives in this area.

There is, of course, one thing we all agree on, if only because most of us have seen for ourselves how a devastating illness can destroy the financial security of a family.

We must work to make sure that skyrocketing medical costs don't wipe out the life savings of millions of elderly Americans who live under the ugly specter of catastrophic illness.

I seriously doubt whether anyone in this room would oppose a plan to provide peace of mind for these elderly Americans.

But that isn't the question, Mr. Chairman. The question is how we're going to pay for that peace of mind.

In my opinion, the President's plan is a prudent one. That's why I support it. The bill contains no massive spending proposals that could, over time, bankrupt Medicare and increase the deficit.

There are however, several problems with the administration's bill:

First, I'm not sure our senior citizens fully understand what this plan will—or will not—cover, or how their existing "MEDIGAP" policies would need to be revised to mesh with this plan.

Clearly, there is a great deal of work to be done in educating and reassuring those who would be served by this program.

Second, the President's plan does not address two of the fastest growing segments of health coverage—home health care and long-term nursing care.

I know that the ranking Republican of this committee, Senator Hatch, is planning to introduce a home health care bill and I look forward to working with him.

But before we expand the long-term health care debate to include either of these two areas, I think we need to be realistic about what we can afford right now.

Third, we need to make sure we don't blindly rush into a national health insurance plan that undercuts the very valuable contributions our private sector has made in this area.

And fourth, the President's plan doesn't cover other important costs—prescription drugs and dental costs, to name just two.

Without question, the President's proposal is a good first step. It takes us in the direction we need to be going.

My only fear in this debate is that, as we so often do here, we'll step off the path the administration has charted for us and take a few unnecessary and ill-considered detours along the way.

As we put together a catastrophic health insurance package, let's not create a program that is equally as catastrophic to Medicare, the budget deficit and the private health care field.

Mr. Chairman, in closing, I'd like to say that I've already mentioned one Hoosier—Secretary Bowen—who has contributed quite a lot in this debate.

Well, I'd like to take this opportunity to welcome another Hoosier at today's hearing—Louise Crooks of West Lafayette, Indiana—who is also certain to make her mark in this area as the next President of the AARP.

OPENING STATEMENT OF SENATOR GORDON J. HUMPHREY

Senator HUMPHREY. Good morning. In my view, the catastrophic health plan advanced by Secretary Bowen creates the very real possibility of another runaway, open ended entitltement program.

Equally distressing is the timing: The Congress will be legislating at a time when health care inflation is rising—a 7.7 percent increase in 1986—at a pace far in excess of the Consumer Price Index. This proposal may well exacerbate the situation. And there are many in Congress who wish to dramatically expand the Bowen proposal.

Few seem to look at expanding the already thriving private Medicap insurance system. I urge my colleagues to look into the feasibility of building on the private system now in place, which would at least be subject to a greater degree of cost control.

[The prepared statement of Senator Cochran follows:]

STATEMENT FOR THE RECORD

SENATOR THAD COCHRAN
COMMITTEE ON LABOR AND HUMAN RESOURCES
APRIL 8, 1987

CATASTROPHIC HEALTH INSURANCE FOR MEDICARE BENEFICIARIES

MR. CHAIRMAN, I COMMEND YOU FOR HOLDING THIS HEARING ON ONE OF THE MOST SERIOUS ISSUES FACING ELDERLY AND DISABLED INDIVIDUALS TODAY -- HOW TO DEAL WITH THE INCREASING COST OF ACUTE HEALTH CARE. I WAS AN EARLY SUPPORTER OF THE CATASTROPHIC HEALTH INSURANCE PROPOSAL DEVELOPED BY SECRETARY BOWEN, AND I AM PLEASED WITH THE SCOPE AND THE SUBSTANCE OF THAT INITIATIVE.

I AM AWARE, AS I AM SURE MOST OF THE MEMBERS OF THIS PANEL ARE, THAT THE SECRETARY'S PROPOSAL DOES NOT ADDRESS EVERY POSSIBLE CIRCUMSTANCE OR ILLNESS AN INDIVIDUAL MAY ENCOUNTER IN A LIFETIME. I DO NOT BELIEVE ANY OF THE OTHER PROPOSALS DO EITHER. IT DOES, HOWEVER, REPRESENT A STEP TOWARD ADDRESSING A

FUNDAMENTAL GAP THAT EXISTS IN THE HEALTH INSURANCE COVERAGE OF MANY ELDERLY AND DISABLED AMERICANS.

EVERYONE IS AWARE THAT CATASTROPHIC ILLNESS IS NOT AN EXCLUSIVE PROBLEM OF THE ELDERLY, OR THE DISABLED. THERE ARE YOUNG FAMILIES, WITH CHILDREN; SINGLE PEOPLE WITH LOW-PAYING JOBS AND INADEQUATE HEALTH INSURANCE; AND MANY OTHER PEOPLE WHO HAVE EXPERIENCED AN ILLNESS OR HEALTH CONDITION THAT DEVASTATED THEIR LIVES AND THEIR FINANCES. WE WANT TO HELP THEM TOO.

I BELIEVE, THOUGH, THAT THE CAREFUL AND CALCULATED APPROACH IS THE WISE ONE. WE HAVE ACKNOWLEDGED THE PROBLEM. SECRETARY BOWEN AND HIS CAPABLE STAFF HAVE PROVIDED THIS COMMITTEE WITH THE FRAMEWORK TO BEGIN TO DEVELOP THE SOLUTION. THIS HEARING THIS MORNING IS EVIDENCE OF OUR INTEREST AND CONCERN IN MOVING FORWARD ON THIS ISSUE.

I HOPE THAT MY COLLEAGUES WILL CONSIDER FAVORABLY THE APPROACH TO CATASTROPHIC ILLNESS PROTECTION AS PUT FORTH IN S. 592, LEGISLATION THAT IS BASED UPON SECRETARY BOWEN'S PROPOSAL.

We will now hear from our first panelist, our colleague, Senator Sasser, from Tennessee, who has a very imaginative and creative program that deals not only with acute care but also long-term care, and that suggests a very innovative structure—a new Part C Medicare program. We look forward to his testimony and the testimony of our good friend, the distinguished former Senator and current Congressman Claude Pepper, who is the leading spokesman in our country for all of the concerns of our senior citizens.

I will recognize Senator Sasser first.

STATEMENTS OF HON. JIM SASSER, A U.S. SENATOR FROM THE STATE OF TENNESSEE; AND HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS, FROM THE STATE OF FLORIDA, AND CHAIRMAN, HOUSE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

Senator Sasser. Mr. Chairman, I want to thank you for inviting me here today, and I want to commend you and the other Members of this Committee for holding these hearings. And I am especially pleased, Mr. Chairman, to appear here today with my long-time friend, Congressman Claude Pepper, who has really led the way for decades now in fighting for the needs of the elderly in this country.

In my judgment, the single most pressing social issue on our legislative agenda this year is the subject of catastrophic health care. Now, there is general agreement, I think, on all sides that we have a very serious problem. There is not, I am sorry to say, general agreement on the solution.

Mr. Chairman, if we look at this whole matter historically, most Americans, I think, breathed a profound sigh of relief in 1985 when Congress established the Medicare Program. Many Members of this Committee including yourself, Mr. Chairman, played a very vital role in the establishment of that very valued and long-needed program.

But with the creation of that landmark health care insurance system, people in the United States for the first time felt that they could count on adequate health care in their retirement years. But today, as has been noted, the elderly are paying as much out of their out-of-pocket funds for health care as they did prior to the passage of Medicare.

Now, there is a fundamental paradox in the Medicare Program. Medicare, which is the Federal Government's health program for the elderly, virtually ignores the most common health care needs of senior citizens. It offers almost no coverage for chronic or long-term care services. And this is by far the most devastating expense facing the elderly, is the cost of long-term care.

And Medicaid, the poverty health program, is the only alternative for many elderly Americans. And it throws chronically ill citizens of modest means into a very cruel catch-22 situation. They find themselves, even though they are of modest means, too affluent for Medicaid benefits, and their health care needs are not covered by any other Government insurance program.

They find themselves in the situation of having to spend down to the poverty level in order to get Medicaid protection. Now, because of the frustration and the genuine fear created by this vicious cycle, nearly 70 percent of the elderly in this country have purchased private supplemental policies. They believe that their so-called "medigap" policies will pick up everything that Medicare does not pay. And this is perhaps the cruelest hoax of all, because it simply is not so.

Most medigap policies leave senior citizens vulnerable to the very problem that they are trying to insure themselves against—the cost of long-term care.

Now, we have seen, I think, many abuses in the sale of these so-called medigap policies. In my own State of Tennessee, we are now uncovering situations where senior citizens have been sold great numbers of medigap policies, the same individual, and then when they become eligible or need long-term health care, none of these so-called medigap policies really meet their needs.

So the conclusion is clear. If we are to offer our elderly full health care protection and save them from the disaster, financial disaster, of long-term care, we must expand the Medicare program. We must close the long-term health care gap.

And that is why, Mr. Chairman, I have introduced legislation very similar to what Congressman Pepper has introduced in the House, that restructures Medicare to create a new Part C program. Now, Part C as outlined in our bills offers the elderly financial protection against all catastrophic illnesses, including those that require long-term care.

If this bill becomes law, our seniors will not have to impoverish themselves and impoverish their children to pay for necessary health care.

The Part C program also gears Medicare coverage more towards keeping the elderly healthy. We are talking in terms of prophylactic medicine. It greatly improves our seniors' access to preventive care, which can help them avoid lengthy hospital and nursing home stays.

And finally, and I think equally as important in this day of fiscal austerity, this proposal is not—I want to repeat, not—a budget-buster. It entails no increase in Federal expenditures; it would be financed through existing Medicare funds, through beneficiary payments, and savings in Federal Medicaid payments to the State.

Mr. Chairman, in December of last year, I held hearings on catastrophic illness and its financial impact on citizens of my State. And in those hearings, Mrs. Dean Carr of Piney Flats, Tennessee testified about her 92-year-old father who was suffering from cancer and confined to a nursing home.

He had Medicare, and he had at least one of the so-called medigap insurance policies. But neither of these covered his nursing home costs, which were running about $2,000 a month. And this middle-class family quickly found that they were exhausting not only the residue of their father's estate, but also their own financial resources in an effort to care for him.

Mr. Chairman, it is sad to say and sad to hear this. I remember Mrs. Carr testifying about her father, who ended saying, "I just pray that no one in this room ever has to go through what we have gone through, because it simply tears your heart out, having to serve between your father's needs and those of your children."

But unless we act, I think literally millions of American families are going to have to face the same kind of heart-rending experience. Congress does not have the power to ease the physical and emotional pain of the elderly who need long-term care, but it can ease the financial pain for families like the gentleman I have just discussed.

I submit, Mr. Chairman, that there is a promise implicit in the 50-year history of legislation that began with Social Security. It is a promise that Americans who have worked hard all their lives will not end their lives impoverished and a burden on their children. It means that the elderly will not prefer death to living and being a burden on those that they love.

In the words of the famous song, "Old Man River", we do not want our elderly in the position of being "tired of living but feared of dying." And that promise will not be fulfilled until we solve the problem of long-term care.

Again, Mr. Chairman, I thank you for allowing me to appear here this morning.

I am going to have to take my leave very rapidly, if I may, because I was supposed to begin chairing some other hearings about five minutes ago.

The CHAIRMAN. Thank you very much, Senator Sasser.

We will look forward to examining your proposal. We wanted to question you a bit about the financing mechanism, which was enormously interesting, but maybe Congressman Pepper could address that.

Congressman Pepper, we are delighted to have you, and we look forward to your testimony.

Mr. PEPPER. Mr. Chairman and Members of the Committee, I am particularly grateful to you for having me here this morning. I appreciate the privilege very much. I commend my distinguished friend here, Senator Sasser, for the excellence of the statement that he has just made.

Mr. Chairman, you know, I feel like I am bringing coals to Newcastle when I come before you and this Committee to talk about the need for catastrophic health care to protect the elderly and indeed all the people of our country.

But Mr. Chairman, with the utmost of sincerity, I feel it is proper and honest to say that the question now is not for us to determine what we should do, but for us to do what we know we must do in respect to this critical matter. And it may be that the time has come to start voting upon these critical measures to give the American people, our constituents back home, an opportunity to pass their own judgment upon the adequacy of our response to their demands that we have comprehensive health care to protect all the people of the United States.

Mr. Chairman and Members of the Committee, you remember the long struggle that was engaged in by Members of this Congress to get adequate coverage for the health care of the people of this country. My first recollection of any effort of that sort involves a great Senator from New York, Senator Bob Wagner, who was my colleague then in the Senate. He offered a comprehensive program for health care coverage, a social insurance program comparable to Social Security. Nothing was done about that.

In 1945, President Harry S. Truman sent a special message to the Congress, urging the Congress to pass such a program of comprehensive health care coverage. He also added research and the like—hospital facilities, and more things like that—for the protection of the health of the American people. Nothing was done about that.

In 1946, my Committee on Wartime Health and Education in the Senate, dealing with the question of why 4 million young men of draft age were not mentally and physically able to respond to the call of their country in time of war as draftees, recommended after a three-year study in the Senate a comprehensive health care program of similar character. Nothing was done about that.

Then, along finally came 1965. That was a landmark year, and we did make some landmark decisions with the enactment of the Medicare program and the Medicaid program. We surmised—and several of us were Members of the Congress when that action was taken—that, if we took care of the old folks and took care of the very poor, the middleclass could take care of itself. After 22 years of experience, we have found that is not true.

I know of no better illustration of that than two cases that came to my attention recently, when my Subcommittee on Health and Long-Term Care in the House held some hearings on this subject.

I got a letter from a man in Maine, 83 years old. He said, "I am the loneliest man in the world. My wife of 55 years has Alzheimer's disease. Her condition has steadily worsened. I had to put her in a nursing home."

He said, "Then, a while later, I had a stroke, and I had to have one of my legs removed. After that, I had some other health problems. Now my wife has been in the nursing home for several years, and I am desperate. What am I going to do? We have almost exhausted our savings of $160,000."

Now, how many Americans have $160,000 in the bank?

Another man named Howard appeared in person before our Committee—and incidentally, he told us at the hearing that he called the White House, and he said, "I am going to appear over there in the House before Mr. Pepper's Committee today. I wish you would send somebody over there to hear what I am going to say. I think you should hear it."

Here is what he said. He said, "I was 58 years old. I was in good health. I had a good job. My wife and I owned a comfortable home. We had four health insurance policies on our health and we had $140,000 in the bank. I thought I was all right and my family was safe."

And then what happened? He got the same word I got one day: "Your wife has cancer." And she had to go into a nursing home. He said not long after that he had a serious stroke. Then not long after that he had an automobile accident. And he said, "With my disability, my inability to work, my wife being in a nursing home, we have just about exhausted our savings of $140,000"—above the average for the middle class of our country.

So the truth of the matter is we have learned after 22 years' experience that Medicare is not adequate to meet the needs of the people of the country. It does not cover long-term hospital care, which is an element in the benefit package of the Bowen bill. We should cover all the hospital care, of course. However, the Bowen proposal does not cover nursing home care, which is the main demand. It does not cover home care.

The elderly spend $10 billion a year buying drugs. It does not cover a penny they pay for drugs that they consume out of the hospital. It does not provide any money for eyeglasses or hearing aids—I wear a hearing aid; they cost $550 apiece. Everybody cannot afford the hearing aids that they need. The Bowen bill does not cover any of that.

Dental care is not included. You will see so many of the elderly people toothless; they cannot eat adequately. They do not have the money to buy the dentures that they need. And the Bowen bill does not cover that.

And there is another common sort of an ailment that is meaningful to a lot of the elderly, and that is foot care. It does not cover any of that, either.

I know of no better way to summarize the inadequacies of the Bowen bill than the language of Dr. Edward Campion of the Harvard Medical School faculty, who is also on the staff of the Massachusetts General Hospital. He says, "The current proposal does very little. For example, lifting Medicare's 150-day limit would have affected less than one-tenth of one percent of our patients at Massachusetts General Hospital. Last year, only 17 patients out of over 33,000 would have qualified. By contrast, nearly 2,000 patients were discharged to rehabilitation and chronic hospitals and to nursing homes, where Medicare support soon vanishes, and the slide toward impoverishment begins."

"These ill, frail patients need help beyond acute hospitalization; they need an extension of Medicare that is fiscally sound, but does not simply rob other benefits."

And he describes the feeling of some of the elderly by saying, "Those are the fears of my 83-year-old patient, slowing dying of chronic rheumatic heart disease, trying to remain in her own home. Quote, 'I fear many things, but death is not one of them,' she said. She feared all those things not covered by the Administration's proposal."

Now, Mr. Chairman and Members of the Committee, I realize that this is a complex subject. I realize we need much data before we can act wisely and exercise sound judgment upon the matter. But I think the time has come to face the issue squarely. Are we going to adopt the proposals in principle which are the policies of all the enlightened nations of the world except the United States and South Africa, or are we going to remain in that limited category of countries with no comprehensive health insurance?

The other day, down in Miami Beach, in my district, I had given a flag to some of the elderly people at one of the elderly housing projects. Afterwards, we came in and sat down around the table to have coffee. Among the group was a lady from Canada. She said, "I do not understand how, in the United States, these things that you say can be true. In my country, none of those costs would be paid by me; they would all be covered by our health program." She said, "I am at a loss to understand why the United States, great, advanced country that you are, has not adequately met the challenge of this Canadian program."

Now, what are we afraid of? I do not think there is any doubt about the need or the people's demand that we do something adequate. I have got a report here of two polls. One of them was a recent national poll by the Daniel Yankelovich group, a respected independent pollster. It found that three out of four Americans, young and old alike, supported the expansion of Medicare to include the cost of long-term care. And then, in December 1986, a survey sponsored by AARP revealed that 82 percent of Americans age 45 and over favor a Government program to help pay for long-term care.

The skeptics say, "Well, it will cost a lot." I do not care what it costs, it is less than is paid now by the people of the country under the present system. And it will ruin nobody. The present system ruins one million people a year.

Our Committee has established the fact that one million Americans a year become destitute because of having to pay for their medical care under the present system that we have. Nobody will be made destitute by any proposal that I know of, certainly not by mine or Senator Sasser's or any others.

I think the time has come for us to face up to reality. If we do not have all the data we need, we should get it. It is better to pass something in October or January of next year than to pass a bill that is inadequate now. You and I know very well the tendency of the Congress, once we have dealt with a subject not to come back to it for no telling how long thereafter.

We have waited 22 years to enact any meaningful legislation in the health field since we passed Medicare in 1965. Are we going to wait 22 more years? How many people are going to die during that period of time for lack of care?

Let me just tell you one more experience that I had. A little bit ago, a lady came and sat down at my desk. She said, "Mr. Pepper, my mother used to work for you in Miami and she is the reason I came to you. I now live in Houston. I am 35 years old, I have three children, and I am the source of support for my mother." She said, "If you will look in my eyes, you will see the eyeballs have already turned yellow. I have got a liver disease. I have been to the doctors and the hospitals in the East. They tell me that if I do not have a transplant in the next six or nine months, I will be dead in the next 12 months."

"I have been to these hospitals, and they tell me it will cost $150,000, maybe $200,000 altogether, to have that transplant. I have been able to raise by solicitations among people of kind heart, $45,000."

"What am I going to do? I have come to you and ask you to help me."

There was a mother and a daughter, an American citizen, pleading before a Member of Congress to live.

I called up David Stockman. I said, "I have got a critical case here before me. Is there any program you know of in the Federal Government under which we can give any help to this lady?"

He said, "I do not know of any. I will check and call you back." He did call back and said he didn't know of anything.

Well, to make a long story short, that lady had the temerity and the initiative to campaign all over America. She finally raised

$120,000—a marvel. She had an operation at the Deacon's Hospital in Boston for $120,000, much less than the usual sum that they charge. She had the operation.

A few days ago, she and her mother came and had lunch with me over at the Senate Dining Room. She had gained 60 pounds from the medicine she has to take to keep the body from rejecting the transplant. But she said, "Mr. Pepper, your bill will not do me any good at all." My bill, H.R. 65, is related to the elderly.

I asked, "Why?"

She said, "Well, because in the first place, I am not 65. Furthermore, it is costing me $1,000 a month to buy the drugs I have to take to keep the body from rejecting the transplant that I have already had. I will be dead in a little while if I stop taking that medicine."

And she said, "Medicare is telling me they are going to stop giving me that money because they do not accept a transplant of a liver as an approved method of medical care."

I called Dr. Roper at HCFA about it, and you might want to check into it yourself. They said, "We are waiting on the National Institutes of Health to give us an opinion as to whether it is an accepted operation or not."

Anyway now, here is that lady. Who is going to keep her alive? If they cut off her $1,000 a month, she says, "I cannot work. I cannot rely on solicitations indefinitely." What is going to happen to that lady? These are just a few cases.

One more. The other day, we had five witnesses before our Subcommittee. When the catastrophic illness struck these respective families, every single one of them lived in their own home, they all had good jobs, they all had a good many thousand dollars in the bank, they were all living comfortably—good, middle-class Americans.

Then catastrophic illness struck each one of those families. First went the savings and then the homes. I will never forget the agony with which one elderly woman told us about having to sell their home. She said, "I had to take care of my husband. We had exhausted our savings. We had no other resources. I did not know where else to turn. We had to sell our home. But," she said, "I dare not tell my husband that I had to sell our home because it would break his heart to know that."

So I am saying that what we are proposing is merely a tax, and we want the program to be self-supporting. I do not want to add to the deficit, I do not want to add to the debt. God knows, we have got enough of that already.

But let us levy the money necessary to pay the bills. Everybody will be helped and nobody will be hurt by a comprehensive program comparable to Social Security that will provide the revenue with which catastrophic illness will be taken care of for all the people of America.

Now, in conclusion, Mr. Chairman, my bill, H.R. 65, is comprehensive in scope—it covers hospital care, nursing home care, home care, dentures, drugs, eyeglasses, foot care, and the like. It is comprehensive and it is self-supporting. I am waiting now on a report from the Congressional Budget Office. I have asked Representative Stark, who is holding the hearing of the Ways and Means Subcommittee, not to conclude his decision until he can get the report of the Congressional Budget Office as to the cost of my bill. So I want to know what the cost is going to be. Of course, if we need to vary the method, I am ready to do that.

I am merely saying, Mr. Chairman, the time has come for us to face honestly and squarely the magnitude of this challenge. Remember, it is not just a theory. It is not just political science. It is life and death; it is destitution as the only alternative for many of the people of our country.

So I commend your distinguished Committee for the serious thought that you have given to this matter, and I hope you will take an advance position. Let us meet this challenge and meet it honorably.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Pepper follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, APRIL 8, 1987

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STATEMENT OF
CONGRESSMAN CLAUDE PEPPER, CHAIRMAN,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
OF THE
U.S. HOUSE SELECT COMMITTEE ON AGING
BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
ON

"CATASTROPHIC HEALTH INSURANCE FOR OLDER AMERICANS"

MR. CHAIRMAN. MEMBERS OF THE COMMITTEE. LADIES AND GENTLEMEN. I WANT TO THANK MY DISTINGUISHED COLLEAGUE AND CHAIRMAN OF THIS COMMITTEE, THE HONORABLE TED KENNEDY OF MASSACHUSETTS, FOR THE PRIVILEGE OF LETTING ME TESTIFY ON A MATTER OF IMMENSE IMPORTANCE TO OUR NATION'S 31 MILLION ELDERLY AND DISABLED, THAT IS THE NEED IN THIS COUNTRY FOR COMPREHENSIVE CATASTROPHIC HEALTH INSURANCE.

MR. CHAIRMAN. OVER THE COURSE OF THE LAST FOUR YEARS, MY SUBCOMMITTEE HAS HELD DOZENS OF HEARINGS ON THE ISSUE OF CATASTROPHIC HEALTH INSURANCE, BOTH IN WASHINGTON, D.C. AND AROUND THE UNITED STATES. LITERALLY HUNDREDS OF ELDERLY MEN AND WOMEN HAVE APPEARED BEFORE MY SUBCOMMITTEE TO DETAIL THEIR PERSONAL EXPERIENCES IN COPING FINANCIALLY WITH A HEALTH CARE TRAGEDY. ELDERLY AMERICANS ARE AFRAID. EVERY DAY THEY FACE THE DOUBLE-EDGED SWORD OF EVER-ESCALATING HEALTH CARE COSTS AND CONSTANTLY DECREASING MEDICARE COVERAGE. EVERY DAY, THEY FEAR GOING BROKE, LOSING THEIR HOME TO A LONG-TERM ILLNESS, GOING INTO A NURSING HOME, OR BECOMING DEPENDENT ON A STRANGER OR A LOVED ONE. MOTIVATED BY SUCH FEAR, MY SUBCOMMITTEE HAS FOUND THAT SENIOR CITIZENS BUY HOPE IN THE FORM OF ONE OR MORE INSURANCE POLICIES, NOT REALIZING THAT THERE IS NO PUBLIC OR PRIVATE INSURANCE POLICY, OR COMBINATION OF SUCH POLICIES, THAT WILL PROTECT THEM WHEN A CATASTROPHIC ILLNESS STRIKES AND PROVIDE THEM WITH THE COMPREHENSIVE COVERAGE THEY SO DESPERATELY WANT.

WHILE MEDICARE AND PRIVATE INSURANCE DO A PRETTY GOOD JOB OF PAYING COSTS ASSOCIATED WITH HOSPITAL STAYS -- VIRTUALLY NO COVERAGE IS AVAILABLE FOR THE 20 MILLION AMERICANS WHO SUFFER FROM CHRONIC HEART CONDITIONS, OR THE 10 MILLION AMERICANS WHO SUFFER FROM CHRONIC LUNG DISEASE, THE 3 MILLION AMERICANS WHO HAVE ALZHEIMER'S DISEASE, THE 5 MILLION AMERICANS AFFLICTED WITH CANCER, OR THE 500,000 AMERICANS WHO HAVE PARKINSON'S DISEASE. IT IS A FACT THAT ONCE A PERSON BECOMES SO DESPERATELY ILL THAT THERE IS NO HOPE OF MAKING HIM OR HER SELF-SUFFICIENT, MEDICARE AND MOST PRIVATE INSURANCE COME TO AN END, AND THE PATIENT AND HIS OR HER FAMILY ARE LEFT TO FEND FOR THEMSELVES. THE SUBCOMMITTEE HAS FOUND THAT LIFE SAVINGS CAN QUICKLY BE DEPLETED FROM COSTS ASSOCIATED WITH A CATASTROPHIC ILLNESS -- WITH LONG-TERM CARE IN THE HOME OR IN A NURSING HOME RANGING FROM $25,000 TO OVER A MILLION DOLLARS A YEAR.

THE OPTION FOR CHRONICALLY ILL AMERICANS WHOSE RESOURCES ARE EXHAUSTED, OR NON-EXISTENT, CAN BE EQUALLY FRIGHTENING. ONE IS ADVISED TO WAIT UNTIL ALL LIQUID RESOURCES, INCLUDING ONE'S HOUSE, ARE DEPLETED TO THE LEVEL OF $3,000 FOR A COUPLE AND $2,500 FOR AN INDIVIDUAL -- AND THEN GAIN MEDICAID ELIGIBILITY.

IN 1987, OVER 700,000 OLDER AMERICANS WILL BE FORCED INTO POVERTY AND ONTO THE WELFARE ROLLS DUE TO THE CATASTROPHIC COSTS OF THE HEALTH CARE THEY NEED.

WHILE I AM PLEASED THAT THE PRESIDENT NOW AGREES THAT WE MUST ASSIST OUR ELDERLY AGAINST THE BANKRUPTING COSTS OF A CATASTROPHIC

ILLNESS, I AM SHOCKED THAT HE WOULD KNOWINGLY OR UNKNOWINGLY LEAD THE AMERICAN PEOPLE TO BELIEVE THAT THE PLAN HE ENDORSED WOULD "FREE THE ELDERLY FROM THE FEAR OF CATASTROPHIC ILLNESS" AND PROVIDE "THAT LAST FULL MEASURE OF SECURITY." THAT CLAIM IS SIMPLY NOT TRUE.

THE PRESIDENT'S PLAN SIMPLY COVERS LONG HOSPITAL STAYS -- WHICH LESS THAN 1 PERCENT OF THE ENTIRE MEDICARE POPULATION CURRENTLY REQUIRES. IN EXCHANGE FOR A $4.92 MONTHLY PREMIUM, MEDICARE WOULD COVER AN UNLIMITED NUMBER OF DAYS IN A HOSPITAL, WITH EACH MEDICARE BENEFICIARY PAYING NO MORE THAN $2,000 EACH YEAR IN COINSURANCE AND DEDUCTIBLES. SIMPLY PUT, HIS PLAN WOULD HELP ONLY 3 PERCENT OF THE TOTAL MEDICARE POPULATION. A POLICY EXPERT FROM HARVARD TOLD MY SUBCOMMITTEE LAST WEEK THAT THE WHITE HOUSE PLAN WOULD HELP ONLY ABOUT ONE-TENTH OF ONE PERCENT OF ALL MEDICARE PATIENTS AT THE MASSACHUSETTS GENERAL HOSPITAL. THE PRESIDENT'S PLAN WOULD NOT COVER THE HEALTH CARE COSTS FOR VICTIMS OF ALZHEIMER'S, PARKINSON'S, HUNTINGTON'S, CHRONIC HEART OR ARTHRITIC PROBLEMS, CANCER AND THE LIKE. HIS PLAN WOULD NOT COVER LONG-TERM CARE IN THE HOME OR IN A NURSING HOME -- WHICH IS THE REAL CATASTROPHE FOR OLDER AMERICANS. IT DOES NOT COVER PRESCRIPTION DRUGS WHICH COST OVER $10 BILLION ANNUALLY. IT WILL NOT COVER HEARING AIDS WHICH AVERAGE AROUND $500 EACH. HIS PLAN WOULD NOT COVER EYE CARE, FOOT CARE, DENTAL CARE, PHYSICAL EXAMS.

I HAVE RECEIVED THOUSANDS OF LETTERS FROM SENIOR CITIZENS ACROSS AMERICA SINCE THE PRESIDENT'S ANNOUNCEMENT ON CATASTROPHIC HEALTH CARE. NOT ONE LETTER HAS COME FROM THE VICTIM OF A LONG AND UNCOMPENSATED HOSPITAL STAY, ALTHOUGH I UNDERSTAND THAT YOU WILL HEAR TESTIMONY FROM SEVERAL TODAY. SADLY, MOST WRITERS BELIEVE THAT THE PRESIDENT'S PROPOSAL WILL PROVIDE THE ASSISTANCE THEY SO DESPERATELY NEED. BUT THE PRESIDENT'S PLAN WON'T HELP THE 83-OLD-GENTLEMAN FROM MAINE WHO WROTE ME STATING:

> ...HERE I SIT THE LONELIEST MAN THAT EVER LIVED. I HAVE ADMITTED MY WIFE, OF 55 YEARS, TO A NURSING HOME. SHE HAS ALZHEIMER'S AND I AM CAUGHT BETWEEN A ROCK AND A HARD PLACE. I CAN NO LONGER PROVIDE THE ROUND THE CLOCK SHE REQUIRES AND I WILL SOON BE UNABLE TO PAY THE COSTS OF THE CARE SHE NOW RECEIVES WHICH HAVE EXHAUSTED OUR $160,000 IN LIFE SAVINGS.

THE PRESIDENT'S PLAN WON'T HELP AN ELDERLY GENTLEMAN FROM MARYLAND WHO TESTIFIED BEFORE OUR SUBCOMMITTEE SEVERAL WEEKS AGO. HE SAID,

> ...IN 1983, MY WIFE WAS STRICKEN WITH CANCER. IN THE YEAR THAT FOLLOWED PRIOR TO HER DEATH, I SPENT OVER $17,000 FOR HER CARE, OF WHICH MY FOUR INSURANCE POLICIES PAID ONLY $64. MY OWN HEALTH HAS DETERIORATED -- I SUFFERED A STROKE, HAVE A LIVER DISORDER AND MY LEG WAS RECENTLY AMPUTATED. I REQUIRE ROUND-THE CLOCK CARE ALL OF WHICH IS UNCOVERED BY MEDICARE AND MY INSURANCE. I HAVE ALMOST EXHAUSTED MY $140,000 IN SAVINGS.

NOW, HOW MANY OLDER AMERICANS HAVE $140,000 OR $160,000 LYING AROUND? NOT MANY. THESE TWO GENTLEMEN ARE TYPICAL VICTIMS OF CATASTROPHIC ILLNESS IN AMERICA. THESE GENTLEMEN WEREN'T LIVING ON THE FRINGES OF POVERTY. THEY HAD SAVED ALL THEIR LIVES. THEY WERE PROPERLY INSURED. THEY THOUGHT THEY WOULD BE SAFE WHEN A HEALTH PROBLEM AROSE, AND THEY, LIKE THOUSANDS OF OTHERS, WEREN'T. UNFORTUNATELY, THEY WON'T BE HELPED BY THE PRESIDENT'S PLAN EITHER.

ANY SERIOUS CATASTROPHIC HEALTH CARE PROPOSAL SHOULD COVER NOT ONLY LONG STAYS IN A HOSPITAL BUT LONG STAYS IN THE HOME OR IN A NURSING HOME AS WELL. IT SHOULD COVER ILLNESSES LIKE CANCER, ALZHEIMER'S, PARKINSON'S, HUNTINGTON'S, HEART DISEASE, AND THE LIKE, THAT DO NOT REQUIRE HOSPITALIZATION AND WHICH ARE LARGELY UNPROTECTED BY INSURANCE EITHER PRIVATE OR PUBLIC.

I AM HERE TODAY BECAUSE I BELIEVE THAT FOR THE FIRST TIME IN MY CONGRESSIONAL CAREER, WHICH SPANS 50 YEARS, THE PRESIDENT, THE CONGRESS AND THE PEOPLE ARE ALL STANDING ON THE SAME SQUARE. WE ARE FACED WITH THE RARE OPPORTUNITY FOR REAL, LASTING, MEANINGFUL CHANGE WITH RESPECT TO THE FUTURE OF HEALTH CARE. WE CANNOT, IN GOOD CONSCIENCE, WASTE THIS OPPORTUNITY WITH LIMITED REFORM.

I URGE YOUR CONSIDERATION OF THE CONCEPT OF COMPREHENSIVE CATASTROPHIC HEALTH CARE COVERAGE UNDER MEDICARE. I HOPE YOU WILL REVIEW H.R. 65, WHICH I HAVE INTRODUCED, AND S. 454 -- A COMPARABLE MEASURE INTRODUCED BY MY COLLEAGUE IN THE SENATE, THE HONORABLE JAMES SASSER OF TENNESSEE. H.R. 65 WOULD IN FACT PROVIDE OLDER AMERICANS WITH THE CATASTROPHIC AND COMPREHENSIVE COVERAGE THEY ARE HOPING FOR. THE BILL PROVIDES COVERAGE FOR LONG OR SHORT STAYS IN A HOSPITAL, IN THE HOME, OR IN A NURSING HOME. IT WOULD COVER MANY ITEMS CURRENTLY UNCOVERED BY MEDICARE OR PRIVATE INSURANCE, INCLUDING DENTAL CARE, EYE CARE, HEARING CARE, AND PHYSICAL EXAMS.

H.R. 65, AND ITS COMPANION BILL IN THE SENATE, S. 454, ARE DESIGNED TO NOT ADD ONE DOLLAR TO THE FEDERAL DEFICIT. THESE MEASURES ARE COMPLETELY SELF-FINANCING. THEY WOULD CALL FOR A MORE SENSIBLE AND EFFICIENT MANAGEMENT OF OUR HEALTH CARE DOLLAR AND HEALTH CARE SERVICES. THESE BILLS BUILD ON THE SUCCESS OF THE KAISER PERMANENTE GROUP IN OREGON WHICH IS PROVIDING COMPREHENSIVE CARE WITHIN THE COSTS OUTLINED IN S. 454 AND H.R. 65. THEY BUILD UPON THE SUCCESS OF THE ON-LOK PROGRAM IN SAN FRANCISCO WHICH HAS BEEN ABLE TO PROVIDE MORE COMPREHENSIVE CARE WHILE ACTUALLY REDUCING THE COST TO THE FEDERAL GOVERNMENT AND THE STATES. AS YOU MAY KNOW, THE CONGRESSIONAL BUDGET OFFICE IS CURRENTLY PREPARING A COST ANALYSIS OF MY BILL. WE HOPE TO HAVE THEIR REPORT IN THE COMING WEEK.

SUCH A COMPREHENSIVE PACKAGE OF BENEFITS WOULD BE FINANCED, IN PART, BY THE AMOUNT MEDICARE PAYS NOW FOR SERVICES UNDER PARTS A AND B OF THE PROGRAM, AND IN PART, BY THE AMOUNT MEDICARE BENEFICIARIES CURRENTLY PAY FOR PARTICIPATION IN PART B OF THE MEDICARE PROGRAM (17.90 A MONTH) AND THE AMOUNT THEY SPEND PER MONTH ON MEDIGAP INSURANCE (ABOUT $50 A MONTH). IN NO CASE WOULD ANY SENIOR CITIZEN PAY MORE THAN 10% OF THEIR INCOME ON HEALTH CARE PREMIUMS IN A GIVEN YEAR. IN ADDITION, STATES WOULD PURCHASE COVERAGE UNDER THESE BILLS AT A RATE EQUAL TO 90 PERCENT OF THEIR PROJECTED AVERAGE MEDICAID PAYMENTS FOR THESE INDIVIDUALS IN THE FOLLOWING YEAR. WHILE H.R. 65 WOULD PERMIT AMERICANS TO GO TO ANY DOCTOR THEY DESIRED, QUALITY OF CARE AND ACCESSIBILITY OF SERVICES WOULD BE REQUIRED UNDER THESE BILLS.

MR. CHAIRMAN. NO ONE KNOWS BETTER THAN YOU OF THE DESPERATE NEED IN AMERICA FOR MEANINGFUL, LASTING, AND AFFORDABLE HEALTH CARE. I URGE YOU, MR. CHAIRMAN, TO CHAMPION THIS NOBLE OBJECTIVE HERE IN THE SENATE. HOW LONG CAN AMERICA WAIT? HOW MANY MORE AMERICANS MUST DIE IN THE ABSENCE OF APPROPRIATE CONGRESSIONAL ACTION.

The Chairman. Thank you.

I think all we could say is "Amen" to that very eloquent and challenging statement and comment. I would just add a footnote. As the good Congressman knows, for example, in Canada, they are spending about 9.6 percent of their GNP. We are almost up to 11 percent. We are spending $460 billion a year, about $50 billion a year for administration. They have long-term care; we do not. And the real challenge is the challenge to our humanity and the challenge to our decency, and I think it has been eloquently stated by the Congressman from Florida.

I have no questions, and I would ask the Senator from Mississippi if he has questions or comments.

Senator Cochran. Mr. Chairman, let me just join you in thanking my good friend Claude Pepper for being here and contributing to the work of our Committee.

I had the pleasure of serving with him for six years in the House. It is good to see you again, and we thank you for your friendship and your guidance.

Mr. Pepper. Thank you, Senator.

The Chairman. The Senator from Iowa.

Senator Harkin. Mr. Chairman, I have no questions. I just want to again join in saying thank you very much, Claude, for all that you have done for so many years for our Nation. I tell you, you are truly an inspiration for all of us in this country. And no matter where I go in Iowa and visit with people, whether they are in retirement homes, or whether they are at congregate meals, no matter where I go, they always have me carry one word back to Washington: Please say hello, and give our thanks to Claude Pepper.

Mr. Pepper. Thank you, Senator.

The Chairman. The Senator from South Carolina, Senator Thurmond.

Senator Thurmond. I do not have anything further, except we are delighted to have Senator Pepper with us. He has worked long and hard for many years for the elderly, and we want to commend him for his great work.

Mr. Pepper. Thank you, Senator.

The Chairman. Thank you very much.

The Senator from Washington.

Senator Adams. I have no questions, Mr. Chairman. I just want to join in welcoming you here, Claude, and say how much we all appreciate and how grateful we are to you for carrying on the fight that you have for so many years.

Thank you, Mr. Chairman.

The Chairman. The Senator from Maryland.

Senator Mikulski. Well, Congressman Pepper, you certainly have added some salt to this hearing, and we appreciate your comments.

My own father has Alzheimer's disease and is currently incapacitated in a nursing home. So I share with you the grief that occurs in these situations. As you know, Senator Kennedy and myself and Henry Waxman have introduced legislation on spousal impoverishment that would protect the family income of people facing long-term care, and we hope we have your support on that and many other issues.

Mr. PEPPER. Mr. Chairman, may I just say this in respect to Alzheimer's. Perhaps you are already aware of the fact that in the House last session, in the reconciliation bill, Mr. Henry Waxman put a provision in there for five regional centers for research in and treatment of Alzheimer's disease.

Senator Gore and I have previously introduced legislation to provide 20—we think is the right number that we should have.

I got Mr. Waxman to add five more, so there are ten. And I hope we can add to those ten to get the number that we require.

Mr. Chairman, let me just say how proud I am to see three of my recent colleagues in the House who have been promoted over here to your body, sitting here this morning.

The CHAIRMAN. The Senator from New Hampshire.

Senator HUMPHREY. Am I allowed to make a statement here? I have got a very brief statement.

The CHAIRMAN. No. We just want to question Congressman Pepper.

Senator HUMPHREY. I would just say good morning, that is all. Thank you.

Mr. PEPPER. Thank you.

Thank you very much, Mr. Chairman.

The CHAIRMAN. We thank you very much, Congressman Pepper.

Senator HARKIN. Mr. Chairman, I am sorry, I have to be leaving shortly, and I just wonder could I get a statement in the record?

The CHAIRMAN. Yes, without objection, it will be so ordered.

We will have Dr. Bowen, the Secretary of HHS, as our next witness.

Dr. Bowen, we want to welcome you very much to our Committee. You have appeared here before, and we are very grateful to you. I think all of us are very mindful of the very important leadership that you have been providing to address some of the very significant health issues of this country. We know that they are in some instances, controversial, but they are, I think, a very important challenge for our people, and that challenge is whether we are going to be humane and decent to many of our senior citizens. We know you have given a great deal of thought to this, and we know you are very much involved in this issue; you come as a doctor, but also in your own State as a Governor, so you have a very special insight into this, and we are very, very grateful to you for your presence here today.

We recognize someone else at the table, and if you would like to introduce him, he is no stranger to this Committee—or I might yield to my friend and colleague from Utah to make an introduction of one of our witnesses here.

Senator HATCH. Well, thank you, Mr. Chairman. That is awfully gracious of you.

Let me welcome you also, Dr. Bowen. It has taken a lot of guts and intelligence and work for you to come up with this proposal, and we appreciate the efforts you have put in.

I would also like to introduce Thomas Burke, who is with you, who has played a great role in this, and of course, our own former Staff Director on the Senate Committee on Labor and Human Resources, Ron Docksai. We are happy to see you back, Ron, as a witness. I know Senator Kennedy will treat you with utmost deference, but I am going to really work you over today if I get a chance.

Mr. Docksai. I am used to it, Senator Hatch. [Laughter.]

The Chairman. Working for you.

Senator Hatch. Yes. It is very tough working for me, that is for sure.

But we are really happy to welcome all three of you. We are very proud of the record that you are compiling at the Department of Health and Human Services, and we just want to let you know how much we appreciate the things that you have done to cooperate with this Committee to help us all to do a better job.

The Chairman. Secretary Bowen, please proceed.

STATEMENT OF HON. OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY THOMAS BURKE, CHIEF OF STAFF, AND DR. RON DOCKSAI, ASSISTANT SECRETARY FOR LEGISLATION

Secretary Bowen. Thank you very much, Mr. Chairman, Senator Hatch, and distinguished Members of the Committee.

Thank you for the opportunity to discuss the Administration's proposal for insuring the retired and the disabled in our society against the risk of catastrophic, acute health care expenses.

With me today, as you have just said, is my Chief of Staff, Mr. Thomas Burke, and my Assistant Secretary for Legislation, Dr. Ron Docksai. Both served on the Department's Task Force on Catastrophic Health Care, and they are here to assist me.

Health care expenses have been a personal concern of mine for many years, and became my number one priority when I assumed my current responsibilities as Secretary of Health and Human Services. They are also of great concern to the President, who has pursued catastrophic protection both as Governor of California and now as President.

This is a particularly special day for me. While I have appeared before the Congress several times to discuss the contents of my report to the President on catastrophic illness, this is my first opportunity to discuss S. 592, the Medicare Catastrophic Illness Coverage Act, introduced by Senator Dole on February 26th.

And thank you, Mr. Chairman, for your early support of our proposal. We are equally grateful to Senators Hatch, Quayle, Cochran, Pell and others for their leadership on this particular issue.

In crafting the President's proposal, we tried to maintain the fine balance between the needs of all sectors of society. And for what it is worth, it has the enthusiastic support of at least two Medicare enrollees—the President and me.

Now I would like to highlight briefly the steps we took to study the options for catastrophic protection. Many people and organizations throughout the country contributed to our work last year. One major component of our effort was the Blue Ribbon Private-Public Sector Advisory Committee that I established to solicit information throughout the country on the public's concerns and ideas regarding catastrophic health care problems. I am very grateful for the expert counsel that they have provided us.

The other component of our effort was a detailed analysis of policy options for catastrophic illness. Department staff consulted technical experts from around the country to ensure that all possible issues and options were considered. Their work is described in detail in my report to the President, which was also transmitted to you.

Today, I am here to talk about one part of our effort, and that is protecting Medicare beneficiaries against catastrophic health care expenses. But before turning to that, let me underscore that the other issues we studied—that is, protection against long-term care expenses and protecting the general population against catastrophic health care expenses—are also important issues. The President has directed further work on them.

Throughout the development of the catastrophic protection initiative, we have kept in mind the pluralistic nature of our society and its institutions. I believe it is important to preserve the delicate balance between Federal programs, State and local efforts, provider responsibilities, and those of individuals. The diversity of the American health care system helps make it the best in the world, and this system must be preserved.

I now would like to describe for you the Administration proposal and the principles upon which it was based.

Our legislation is structured around three main concepts. First, we would guarantee up to 365 days of hospital care a year, and would limit the hospital deductible to two per year. We would eliminate the "spell of illness" concept and cap total out-of-pocket costs for basic hospital, physician and aftercare services at a fixed amount of $2,000 for fiscal year 1988.

Second, we would fully self-finance the catastrophic benefit through a modest premium added to the current Part B premium. Third, we would limit protection to those expenses associated with the current Medicare benefit. We are not proposing to use the introduction of catastrophic protection as a vehicle to add new services to the Medicare benefit package.

Both the premium and the stop-loss cap would be recalculated annually by Medicare actuaries to ensure that the new catastrophic benefit remains fully self-financed and budget-neutral. It would not result in any intergenerational shift in financing nor be dependent upon general revenues.

The Administration feature added to our original report includes a carryover provision to allow beneficiaries who incur large out-of-pocket expenses at the end of a calendar year to carry these forward into the next year and count them toward that year's catastrophic cap. Since no one can time an illness according to the clock or calendar, having some flexibility in the benefit in this way is fair and reasonable, but not without some added cost.

The carryover provision would affect the premium starting in 1989. The Medicare actuaries are in the process of refining their cost estimates, but this protection if accepted could add as much as 35 percent to the premium for all beneficiaries. Our specific carryover provision is just one of many ways to reduce the possible arbitrariness of an annual accounting period; there may well be other approaches which would provide this type of protection at a more reasonable cost.

The President believes that the mission and purpose of the Medicare program should be to provide health insurance protection, including catastrophic protection for the retired and disabled. While there may be ways to modify somewhat our proposal and still adhere to this view of Medicare, there have been other proposals put forward that would dramatically expand the catastrophic benefit and alter its very nature, adding to the deficit, raising taxes, or expanding Medicare coverage.

Medicare provides the basic core services that individuals will need throughout the course of their lifetimes. There are, and will continue to be, a significant number of services that can be added through the private plans. Coverage for eyeglasses, dentures, and prescription drugs are a few. A great variety of products clearly can be offered by private insurance.

But why finance the benefit through premiums? As you know, Medicare involves two separate benefits—a part A hospital benefit, and a part B, physician and other providers benefit. The part A hospital benefit is funded out of a special payroll tax on workers, and the part B benefit is funded to a large degree—75 percent—by general tax revenues. In this way, current workers pay the hospital bills of the retired and disabled. Current workers are contributing significantly and explicitly to the health care of Medicare beneficiaries.

Our proposal is based on premium financing of benefits, a customary practice in insurance, which would pool the risks widely and keep premiums modest.

I know concerns have been raised about the ability of low-income beneficiaries to afford the added premium for the catastrophic benefit, and I share these concerns. But the Federal Government in partnership with State and local governments, already has programs specifically designed to meet the needs of low-income retirees, disabled, and others. These include Medicaid, Supplemental Security Income, and the Community Health Centers, to name a few. Needs of low-income persons are best addressed through these targeted programs.

Why a $2,000 cap on out-of-pocket expenses? The $2,000 figure itself was arrived at by using the stop-loss coverage we had found in researching private employment-based group health insurance coverage, indexed forward to account for inflation. We believe that a $2,000 out-of-pocket stop-loss is both actuarially reasonable and adheres to a common sense notion of what a catastrophic expense is.

Why limit catastrophic protection to the current Medicare benefits package? We looked at different ways to expand the Medicare benefit. There are a number of services that could have been added over the past 20-plus years, such as prescription drugs, enhanced skilled home coverage, a broadened outpatient psychiatric benefit, or dental coverage. Everyone has a favorite benefit he or she would like to have covered.

This legislation maintains a core set of benefits and services that virtually all beneficiaries will need some day. Medicare is a very good, broad program as it is. It covers hospital stays, nursing home care, rehabilitation, home health care, services of physicians, chiropractors, podiatrists and others. Maintaining the basic Medicare benefit represents an opportunity for the private insurance sector to market benefit packages to those retired and disabled who demand that kind of protection.

Finally, current budgetary constraints make this an inopportune time to promote benefit expansions. Budget neutrality is a linchpin of this legislation.

Our plan balanced competing goals. We provided a basic Medicare benefit package expansion, funded by a premium that is actuarially sound and reasonable.

Consideration of any new benefits would be very costly. We urge that catastrophic protection not be used as a back door for adding new coverage items. Financing new services through the premium would increase costs and discourage some people from enrolling.

One final observation. The bill does not include protection against long-term care costs, and I would be remiss if I did not say a few words about that. Long-term care is high on my list of priorities in the Department. The President has also expressed his concerns.

It became apparent early in our study and deliberations that long-term care was also the dominant concern of the people who appeared before the public-private sector advisory group. It is certainly a major concern of many American families. And I know it is a priority of the Congress as well.

Long-term care was not included in the Administration's bill, however, because it is a very complex problem which is costly to solve. It cuts across many sectors and layers of society. Long-term care involves some medical care services, but the major expenses involve income maintenance and social service needs.

Today about 80 percent of this nonmedical assistance is provided by family and friends, that is through the informal help that so characterizes American society. Any substantial Government intervention will have effects and consequences that are not clear at this time.

Government funding would, without question, increase costs. But the effects on the social fabric would also be large. Family structure and responsibility, community values, intergenerational transfers of assets—these and other societal ramifications need to be fully explored.

Although long-term care needs are great, and the issues complex, that does not mean we should do nothing. We have studied the long-term care issues and plan a number of actions. We will be working with the private sector to educate the public about the risks, costs and financing options available for long-term care, and we will encourage the private insurance sector to develop new long-term care coverage.

We are, of course, well aware of the continuing interest of this Committee in improving and making more accessible long-term care for the elderly. Recognizing your legislative leadership in the provision of chronic care, Mr. Chairman, as well as that of Senator Hatch and others, I share with both of you the sense of urgency about the pressing need for action.

This is why the President has instructed the Treasury Department to study proposals to encourage further the development of the private long-term care insurance market through legislation providing tax incentives for the purchase of such care by individuals or employers.

I sincerely hope the Congress will address this most important issue. But I urge you not to jeopardize the Medicare catastrophic health insurance proposal by burdening it with a long-term care benefit that Medicare, a health insurance program, is not designed to cover.

Mr. Chairman, I would like to leave the Committee with a few final thoughts. Ever since the President brought the issue of catastrophic protection into the national spotlight,the public has become increasingly aware of the gaps in private and public insurance coverage. Your hearing today should help spread the message even further.

The value of this in itself cannot be overstated. Public demand is what fuels change and is what will drive improvements to current insurance packages. As any businessman or woman knows, a knowledgeable consumer is the best customer.

This is a pluralistic society and we all have our own set of responsibilities. The Federal Government need not do all or be all for all people.

We each must do our part: the Federal Government by updating its programs to reflect longer lifespans and the increasing prevalence of chronic diseases; the States, in providing protection against health care expenses for the low-income, disabled and retired; and individuals, in adopting healthier lifestyles and behaviors, avoiding the use of inappropriate or unnecessary services, and planning for their long-term care needs.

And most important, providers must learn to manage better health care services. Health care costs remain a major problem that threatens the Medicare trust funds, State and local treasuries, employers' ability to provide health benefits to employees and their annuitants, and makes health care largely unaffordable for individual purchasers of services.

Better management of medical services, particularly those involving complex illnesses resulting in catastrophic costs, means that more resources will be available for those who truly need them.

We have an exciting challenge before us, Mr. Chairman, and I am delighted to be a part of that solution. Our Medicare Catastrophic Illness Coverage Act is a carefully constructed, well-thought-out piece of legislation, and I hope Congress will give it favorable consideration.

I would be happy to respond to questions that you may have, sir.

The Chairman. Thank you, Mr. Secretary, for a very forthcoming statement.

We will try and run by a seven-minute rule, going back and forth, and see how well we can do, and I will ask the staff if they would watch the time.

Regarding your proposal for a $2,000 cap on the out-of-pocket liabilities for Medicare covered services—we have to recognize that anyone sick enough to accumulate the $2,000 in liability for Medicare covered services probably has had substantial additional liability for uncovered services. Our figures indicate that of the elderly who incur catastrophic costs, more than 15 percent of income spent out-of-pocket for acute services' more than 8 out of 10 hit the catastrophic level without ever reaching the $2,000 level in out-of-pocket expenditures.

First of all, do you agree that those are about the figures?

Secretary Bowen. Yes, I would agree those are about the figures.

The Chairman. So doesn't this suggest that we should be doing more to protect the low-income elderly, either by lowering the catastrophic cap or by expanding Medicaid eligibility?

Secretary Bowen. I suspect it depends entirely on the amount that can be afforded. Our plan does cover the costs that I think are the greatest threat to any catastrophic situation—the hospital bills and the doctor bills. And if you cover those and lessen that burden, then the burden for some of the other expenses that could be accumulated would be much less.

The Chairman. Well, the point I was making is that if 8 out of 10 elderly citizens are going to get to that catastrophic figure before spending $2,000—and many of those are going to be the low-income elderly—should we be thinking in terms of either lowering the cap from $2,000 or expanding Medicaid eligibility.

We know what the earlier response is, and that is the issue of cost. Let us set that aside for just a moment. Wouldn't you recognize that, in a perfect world, we should either lower your level of $2,000 somewhat to try and reach what are the more realistic catastrophic costs, or we should do something in terms of Medicaid coverage, particularly for the low-income elderly?

Secretary Bowen. About 13 percent, I believe, of this group are now eligible for Medicaid, so that leaves another little gap from the percentage that you have stated.

And yes, if you can throw the money question aside, the answer would have to be "yes."

The Chairman. Let me ask about the problem that we have been facing regarding the ability of a spouse to continue a decent lifestyle when a husband or a wife is forced to go into a nursing home. Are you particularly troubled by this evolution of spousal bankruptcy, where we see the lifetime loss not only for the individual who may be in the nursing home, but for the spouse also? In many instances, the well spouses must either sell their homes, or they are pauperized; it is rather a special problem for our seniors. And I am just wondering what comment you would make about it.

Secretary Bowen. I think it is a tragedy when the spouse does have to pauperize himself or herself in order to have nursing home care for the spouse. That, however, is not part of our program. It deals more with the long-term care issue that we did address in our original study. Long-term care is under study now by the Treasury Department to see the impact of what we had recommended on the Federal budget.

The Chairman. Well, we obviously will have to deal with the budget implications. I think both the House and Senate Budget Committees are taking a look at that item. I would hope we might be able to take some action on this.

One of the very serious additional burdens has been the problem with prescription drugs for our seniors. Anyone who meets in a room with elderly people and asks them to raise their hands about how many of them are paying, say, $50 a month or more, will find a high percent of them are spending that on prescription drugs.

We know that prescription drugs are the biggest source of costs for services not covered by Medicare. Senator Thurmond and I introduced legislation a number of years ago to try and deal with this issue.

I am just wondering whether you think there is some additional way we can deal with that very special need, if we can again conform with our own budget process. That is a big "if", but do you recognize some special concerns in paying for outpayment prescription drugs? I think this issue is particularly related to efforts to keep people in home settings, which saves resources in terms of expenditures under the existing programs. It may very well provide some important savings if we could reach out to them.

What are your views about trying to do something additional with regard to prescription drugs?

Secretary BOWEN. The prescription drug expense is probably the third-largest expense that the individual might incur in any illness. Number one, of course, would be the hospital, and number two, perhaps, the physician, and then the drug problem.

But again, if we can cover at least two out of those three, which our plan does, that relieves the beneficiary of that burden, and then the other burden does become much less. But if it is affordable and doable, then it certainly would be desirable.

The CHAIRMAN. My time is up.

The Senator from Utah.

Senator HATCH. Thank you, Mr. Chairman.

Dr. Bowen, you are a family physician, and many of your fellow physicians have been telling me that they face every day patients who could be successfully treated outside of a medical institution or hospital by getting home care. And, that they could get the home care at a fraction of cost of what the institutional care is.

So I have put a couple of illustrations up here on home health care savings. For instance, we had a patient with a spinal cord injury resulting in quadriplegia. Institutional care costs $23,862 per month, as represented by the green, and home care for the same person was only $13,931. So there was as savings of almost $10,000 a month between institutional care and home care.

Looking at the other one there, the $17,783 per month, that was a patient with a neurological disorder—and these figures are real; this happens millions of times, all the time—but yet, a neurological disorder and institutional care was $17,783 per month, compared with home health care costs of $196 per month—or a savings of almost $18,000 per month.

Now, the question is, if you were faced with a patient who could be treated at home, what would your recommendation be? And how do you answer your fellow physicians when they tell you that they could do this for a wide variety of patients and have a tremendous cost savings to the Government as well as the patients themselves.

Secretary Bowen. I have always advocated that the individual should be treated in the least restrictive environment and of course, the one that is the most economical. The only question I would have here "will you get the same quality of care?" If you get the same quality of care, then obviously the home care would be much, much more desirable.

Senator Hatch. Well, in some ways, you may have a higher quality, because they are in an environment that they understand and they feel at home in, and they are more psychologically and psychiatrically secure.

Secretary Bowen. Yes.

Senator Hatch. You have to agree with that, don't you?

Secretary Bowen. That is true.

Senator Hatch. Okay. Well, as you can see, I believe that we can save a lot of money if we provide a system of home care as part of our overall health initiative.

One of your programs supported through the Health Care Financing Committee was called Project Open. That reported savings of $138 per participant per month as a result of its long-term health care delivery services.

Now, I understand that you are awaiting evaluation of that program, Dr. Bowen.

Secretary Bowen. Right.

Senator Hatch. And will you let us know when that evaluation is ready, because we would like to see it. I would like to have what your opinion is, because it seems to me a savings of $138 per participant per month is very impressive, especially in light of the fact that by a margin of nine to one, Americans do prefer home care over institutional care.

Secretary Bowen. We will provide it for the record when the study is completed.

Senator Hatch. There have been some people who have criticized your catastrophic health proposal, primarily because it will only help a small number of current Medicare beneficiaries.

Now, in your best estimate, what are those numbers? Are they primarily elderly, or Medicare-disabled, or the ESRD population?

Secretary Bowen. It is a combination of all those you just mentioned. There are about 90,000 of the ESRD population who would benefit.

Senator Hatch. That is the End-Stage Renal Disease program.

Secretary Bowen. That is right; they would benefit. There are about 3 million disabled, and about 28 million aged who would pay the premium. And I think all of them would have a great deal more peace of mind knowing that their life savings would not be wiped out as a result of catastrophic illiness.

Senator Hatch. A recent GAO study concerning Medigap policies concluded that the minimum standards for supplemental Medigap policies are being met or exceeded; further, about 75 percent of all elderly have Medigap policies.

Now, would you mind addressing the charges that your proposal merely displaces existing private insurance for the elderly and opens the door to enormous deficits in the Medicare Program?

Secretary Bowen. It is my feeling that the Medigap or insurance industry would not be "destroyed" or totally replaced as some have charged. As I have mentioned, insurers would probably have to sharpen their pencils and rewrite some of their policies, but there is still a vast market there. The market would be, of course, for the $2,000 cap and for the things that Medicare does not presently cover. And with all of the publicity and the educational value that these debates have brought about, it certainly seems to me that it would open wide the gates for long-term care insurance.

Senator HATCH. Well, thank you. I am concerned about the administration of the Medicare home care benefit recommendation by HCFA. Senator Kennedy and I are writing to you, asking that you review the denial procedures for home care benefits. The denial rate has increased from 1.2 percent in 1983 to 6 percent in 1986, and I have learned from constituents that these policies are hurting both providers and beneficiaries.

So would you please review this and report back to us what can be done to reverse that particular trend, if you would?

Secretary BOWEN. I am also aware of the concerns that you have raised, and yes, we shall report back to you.

Senator HATCH. Thank you.

Mr. Chairman, I know my time is up. Let me at this time ask permission to put a statement by the National Association of Home care into the record.

The CHAIRMAN. It will be so included.

[The prepared statement of the National Association for Home care follows:]

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MOSS AND WILKINS

STATEMENT BY
THE NATIONAL ASSOCIATION FOR HOME CARE
BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

APRIL 8, 1987

REPRESENTING THE NATION'S HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS AND HOSPICES.

The National Association for Home Care (NAHC) is the largest professional organization representing the interests of home health agencies, homemaker-home health aide organizations and hospices, with approximately 5,000 member organizations. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all who require them.

We are especially interested in the issue of catastrophic health insurance, because the majority of the patients we serve are the frail elderly who are most in need of financial protection to guard against the need to impoverish themselves to obtain necessary health care. Unfortunately, the major proposals for catastrophic coverage currently under discussion focus on acute care, and do not address health problems outside the hospital, such as the need for care now mostly met in nursing homes. Nor do they address the type of services most elderly Americans desire as an alternative to nursing home care, that is, care in their own homes. The fundamental health care need of elderly Americans is not coverage of costly "catastrophic" acute illnesses, but rather the coverage of the far more costly care needed for chronic conditions. According to the Senate Special Committee on Aging, under the major proposals currently being discussed, 8 out of every 10 dollars spent on catastrophic illnesses next year would not be covered. Less than three percent of all Medicare beneficiaries would be aided by these proposals. Any serious catastrophic health insurance proposal must protect the elderly against the cost of long term care, and must include home health care as the first choice for provision of that care when it is medically appropriate.

The current Medicare home health benefit is a limited one. It covers only acute services needed on an "intermittent" basis, that is, daily visits for a two to three week period, and thereafter upon a showing of exceptional circumstances. To be eligible for home health care under Medicare, a person must be confined to his or her residence (essentially homebound), be under the care of a physician, and need part-time or intermittent skilled nursing services (as opposed to daily 24 hour-a-day care) and/or physical or speech therapy. If these requirements are met, a person is eligible for the following services: skilled nursing service, physical therapy, speech therapy, occupational therapy, medical social work, and home health aide services.

I. Congress should enact a meaningful catastrophic benefit with home health care as its main focus

NAHC recommends that Congress enact a comprehensive catastrophic health insurance plan which includes improved coverage for both acute and chronic illnesses.

A meaningful catastrophic home care benefit would require Medicare to pay for home care up to a maximum of what would otherwise be spent on the care of a patient in an institution, similar to coverage under the current Medicaid home and community-based care waivers. Such a plan would require case managers to determine alternative costs of care in settings and to coordinate Medicare services with other services provided in the community, such as adult day care. One example of such a program is the Nursing Home Without Walls program in New York, where the availability of a broad range of alterative services has not only maintained the frail elderly in their own homes, but has done so at an average of 50 percent of the costs that would otherwise be incurred for the patient in a nursing home.

The Nursing Home Without Walls program coordinates and manages the delivery of all services to the patient, and the local department of social services monitors the patient's monthly care costs. In addition to regular Medicaid services, the program also offers medical social services, nutritional counseling, respiratory therapy, respite care, social day care, congregate/home delivered meals, moving assistance, housing improvement, home maintenance, social transportation, personal emergency response system, and case management. By statute, costs for the program may not exceed 75 percent of the average monthly cost of institutional care. As mentioned earlier, despite these additions in services, the program is saving an average of 50 percent of the costs that would otherwise be incurred for that patient in a skilled nursing facility or intermediate care facility.

This is the type of Medicare home health benefit that would be a truly meaningful element of a catastrophic health insurance plan.

A less sweeping benefit, which could be provided without the development of a case management system for Medicare, could be provided by covering a limited amount of personal care, for example, a specified number of hours of personal care per week to maintain functionally impaired individuals in their homes. This type of care would provide a respite for families to enable them to continue to take care of older or disabled family members in their homes. It would also provide services to persons whose other needs can be met by family and neighbors where the caregivers may be reluctant or unable to provide such personal care services as bathing. These personal care services would supplement current community-based efforts, not replace them. Such assistance as part of the Medicare program could increase the situations in which these patients could remain in their homes rather than being placed in nursing homes.

Financing for either of these enhanced home health coverages should be through mandatory participation spread over the lives of workers, similar to current Medicare Part A financing. Such a method would minimize the impact by distributing the financing over the largest possible number of individuals in a progressive manner.

II. Congress should remedy problems with the current Medicare home health benefit

While working on a meaningful home care benefit to include in catastrophic health care coverage, Congress should immediately take steps to remedy problems in the current Medicare home health benefit which are limiting access to the benefit for many Medicare beneficiaries.

Recent policies of the Health Care Financing Administration (HCFA) "to restrain beneficiary protections, combined with vague and confusing guidelines for providers, result in reduced access to home health care for Older Americans", according to a report by the Senate Special Committee on Aging.

The report noted that although hospital discharges to home health have increased 37 percent since prospective payment for hospitals was implemented, the growth in home health services since then has slowed. A 1987 General Accounting Office survey of hospital discharge planners revealed that 86 percent "reported problems with home health care placements" for Medicare beneficiaries. 52 percent of those surveyed cited "Medicare program rules and regulations" as "the most important barrier" to these placements. It is no coincidence that HCFA's own statistics show that the percentage of home health claims denied under the Medicare program rose from 1.2 percent in 1983 to over 6.0 percent in 1986. And this figure does not include the many patients who are effectively denied Medicare coverage because home health agencies, incapable of assuming the costs of non-covered care, avoid Medicare claims submissions.

Intermittent Care Requirement

As noted earlier, the present HCFA guidelines allow for daily visits for a two to three week period, and thereafter, visits may be continued upon a showing of exceptional circumstances. This level of services is often inadequate to care for more acutely ill patients who are being discharged from hospitals.

In addition, definitions of what constitutes "intermittent care" vary tremendously, depending on the fiscal intermediary's (FI's) interpretation. As a result, Medicare, which is supposed to be a national program, is not enforced uniformly and what is covered for one beneficiary in one state is not covered in other state.

A related practice, known as "selective billing," has served to further restrict home care coverage for Medicare beneficiaries. If patients are receiving coverage under Medicare, in many cases they cannot receive additional coverage from Medicaid or any other payment source (private insurance, self-pay, Title XX, etc.). For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week paid for by Medicaire, and he or his family wants an additional 2 hours of nursing care on the other 2 days which will be paid by concerned relatives, Medicare intermediaries will deny the Medicare coverage, claiming that the patient is exceeding the "intermittent care" requirement. This either will result in no care, limited care, or the forced institutionalization of an individual whose family cannot sustain him at home if Medicare refuses to pay its fair share.

Homebound Requirement

The Medicare homebound guideline allows the patient to be considered homebound if he has infrequent or short duration absences from the home primarily for medical treatment or "occasional non-medical purposes" (e.g., trip to barber, a drive, walk around the block).

The current definition in the guidelines is interpreted in an inconsistent and varying manner by fiscal intermediaries. This is especially so in cases where beneficiaries are leaving their homes to go out for periodic adult day care, outpatient kidney dialysis, chemotherapy and other similar treatment. Even though the current guideline allows beneficiaries to go out for medical reasons, some FIs severely limit frequency and others do not honor the medical reason exception at all. In situations where individuals leave their homes for either medical or non-medical reasons, individual FIs have their own interpretations as to what they consider frequent on infrequent, or whether they consider the patient homebound if he or she leaves home with the aid of an ambulance or other extraordinary assistance.

Recommendations:

Congress should:

1. Enact a catastrophic health insurance plan with a meaningful home care benefit as its focus. That home care benefit should require Medicare to pay for home care up to a maximum of what would otherwise be spent on the care of a patient in an institution, similar to Medicaid home and community-based waivers. A less sweeping benefit which could be provided without the development of a case management system for Medicare, could be provided with Medicare covering a limited amount of personal care per week, to assist family and community caregivers in maintaining functionally disabled individuals in their homes.

2. Clarify the definition of intermittent care to include one or more visits per day on a daily basis for up to 90 days and thereafter under exceptional circumstances. Daily care should be clarified to mean seven days per week.

3. Clarify that a Medicare patient should be able to utilize additional payment sources without jeopardizing his Medicare benefit, as long as the care paid for by Medicare is medically reasonable and necessary. The use of other payors should not be relevant to determinations of Medicare coverage.

4. Codify the current homebound guideline and clarify that an individual need not be totally dependent and bedridden to be considered homebound.

We urge Congress to act on these issues to maintain the home health benefit as an increasingly important element in the Medicare program, and to provide meaningful catastrophic health coverage to an elderly population whose health and financial security are both at risk.

The Chairman. The Senator from Washington.

Senator Adams. Thank you, Mr. Chairman. Your questions have covered most of my concerns. I have just one. On page 6 of your testimony, you indicate that you have based your $2,000 cap on a private employment-based group health analysis and that you arrived at $2,000.

What I am concerned about, Dr. Bowen, is we now have a generation coming on-line and moving rapidly through the economy that are not making the wages that the generation before did and do not have the health care packages. And therefore doesn't this program with the $2,000 cap fail to take into account in its basic premise the fact that we will have more and more low-income people that will be impoverished by a $2,000 cap as this generation move through and does not have either the benefit package, which you have analyzed, or the wage level that they presently have?

Secretary Bowen. I believe there may be a little confusion there with the under-age-65 group——

Senator Adams. That are coming in. I mean, this is rotating, as we all know, and a moving target. And what I am concerned about is the Chairman's question that a $2,000 cap, you press people into poverty before they ever reach it. And I am just indicating that I am hopeful that you are in your study taking into account the fact of the changing demographics of the population that is going to be flowing into the 65-year-old group that will not have had the private health benefit plans as part of collective bargaining, for example, nor the wage levels that the study is based on.

Secretary Bowen. One of the parts of our study for the under age-65 group is that we will be working with the States to attempt to get them to mandate that coverage be offered to the group that you are talking about who will eventually end up in the Medicare population.

Senator Adams. So that the States would be requiring that there be health plans of some type to protect this group so that they would have a house or savings or the very things that the present generation is exhausting that this new generation may not have all.

Secretary Bowen. Yes. We are aware that there are 30 million people below the age of 65 who have no insurance at all, and there are another 10 million who have inadequate insurance. We have made a number of suggestions on which we want to work with the States, and one of them is to get coverage for those people who are uncovered in the employment group.

The great majority of those are either self-employed or working for employers with only a very small number of employees, and which do not have the advantages of some of the tax incentives that the larger companies do. Of course, to accomplish that will require some change or legislation at the State level, or even the Federal level.

We have also recommended that for motor vehicle registration, for example, that there be a catastrophic clause in the insurance program for motor vehicle accidents, so that the catastrophic expenses from those will be covered.

One of the biggest causes of catastrophic coverage in the below-age-65 group is due to automobiles, motorcycles and so forth.

We have also recommended that States form risk pools for those who are medically uninsurable and that there be some guaranteed loan programs for the individual who, say, has a pound and a half baby in a neonatal care center for four months at $1,000 a day. That individual may not be able to pay immediately, but over a period of time he or she could. So some innovative programs such as that will help to reduce the uncompensated care and the coverage for these individuals.

Senator ADAMS. Mr. Chairman, I will not pursue it any further now, but I would be hopeful that the Secretary or his staff might submit to the Committee in writing the details that he just testified about so that we have a picture of the demographics of this group.

Thank you.

The CHAIRMAN. Maybe we can sharpen that a little bit, because the owner-operator provisions are very important in terms of the tax legislation, which works to discourage particularly the smaller businesses from getting coverage. We know that has been referred to—I have seen it in your earlier testimony—and I think that is something we would be very interested in. This issue obviously falls under the jurisdiction of the Finance Committee, but it relates to the coverage of smaller businesses.

So I would also like to get your thinking about that and about the risk pools, because we have had legislation dealing with that. There are more than 10 States that are experimenting with risk pools at the present time, and other legislation has been introduced dealing with this subject. Maybe we could inquire for the record some of your thinking on these areas.

Secretary BOWEN. We will supply that.

Senator HATCH. Mr. Chairman, if I could just make one comment, I just want to make sure it is clear—you keep referring to the catastrophic payments of $5.60 per month as "optional". As I understand it, it is only optional if the elderly person opts out of Part B of the Medicare Program. I think that needs to be clarified.

Secretary BOWEN. The part B program, of course, by law is optional, but about 97 or 98 percent of the beneficiaries do take it because it is a real bargain——

Senator HATCH. Sure. But it really is mandatory to pay the $5.60 unless you opt out of Part B.

Secretary BOWEN. Yes, that is right.

Senator HATCH. So it is not really an option.

Secretary BOWEN. You are right, yes. It is an option only insofar as part B is an option, but admittedly again, 97 or 98 percent take part B.

Senator HATCH. So what we are saying is that the Medicare elderly are going to have to pay that in order to have this type of coverage, $5.60 per month.

Secretary BOWEN. Yes, you are right.

The CHAIRMAN. The Senator from Indiana?

Senator QUAYLE. I yield to Senator Thurmond.

Senator THURMOND. Thank you, Mr. Chairman.

Mr. Secretary, we want to welcome you here, and I want to commend you for the fine job you are doing.

I want to ask you this. Congressman Pepper testified this morning about a couple of cases, one of Alzheimer's Disease, in which it exhausted the family's finances, and another was a liver transplant. Would this program cover either of those?

Secretary Bowen. Alzheimer's disease is a chronic disease that would be covered more by a long-term care-type of catastrophic coverage, which our particular bill does not address.

The liver transplant in adults is not covered by Medicare because it is still considered as an experimental type of treatment. It is covered for infants in what we call the biliary atresia, because it is not experimental there anymore. But in adults, it is experimental, and has some questionable results.

Senator Thurmond. I guess the liver transplant would not be included on account of the excessive costs of it?

Secretary Bowen. Excess costs, and because the conditions which destroy the liver oftentimes are such that a liver transplant would not be curative. For example, cancer of the liver would not be an effective means of treatment to have a liver transplant.

Senator Thurmond. Should there be any other program to cover such as that, or do you feel this is about as far as we can go at this time?

Secretary Bowen. At this time, I think that that is as far as we can go, but I will say that the Health Care Financing Administration [HCFA] has this under study constantly.

There are other transplants which will be coming on soon. For example pancreatic transplants, which are still experimental, but have high hope of success.

Senator Thurmond. This is not exactly on the subject, but just what progress is being made with regard to a cure for Alzheimer's Disease?

Secretary Bowen. There is great progress being made as far as finding the cause and potential treatment, but I would say it would be years off before there are great strides in reducing the amount of Alzheimer's.

Senator Thurmond. So far, there has not been found a cause of the disease up to now?

Secretary Bowen. Not an absolute cause, but they are getting close to the cause.

Senator Thurmond. Thank you very much.

The Chairman. Just on this point, I will just take a moment. With regard to question about when treatment ceases to be experimental, it seems to me that those liver transplants have ceased being experimental. That is an administrative decision that is made by HCFA. But I just wonder, in following up on the Senator's question, if a person would qualify for Medicare, and if those liver transplants are continuing to be performed, then it is nonexperimental, and I think that it ought to be covered. I know there may be some difference of opinion on this question, but you are finding out with new technologies, moving along, that things go from experimental to nonexperimental.

Secretary Bowen. Right.

The Chairman. And I think that when treatments cease to be experimental in the true sense, then they ought to be covered. That was what was intended in the law.

Secretary Bowen. When they cease to be experimental, they will be covered in the same way we advocated coverage for heart transplants.

The Chairman. Well, do you think, really, the liver transplants are still experimental?

Secretary Bowen. In adults, yes. And this is not a decision made totally by HCFA or HHS. We have specialists in transplant who give advice on this.

The Chairman. The Senator from Maryland.

Senator Mikulski. Thank you, Mr. Chairman.

Dr. Bowen, it is a pleasure to welcome you here with your unique experience of both being a family practitioner and a Governor. I think you are to be congratulated for giving visibility to the issue of catastrophic care and generating discussion on the wide range of catastrophic illness from acute care to transitional care to long-term care.

In the area of improving the acute care package—and I know that is the focus of the Administration—the AARP later on today will be testifying their recommendations to improve the package that you are recommending to us. I would really like you to take a look at the AARP recommendations. I support these recommendations and wonder then as we fashion the legislative framework if you could support these.

They range from a one-hospital deductible per year and elimination of hospital coinsurance.

I think your proposal is a good starting point, and I would like to see some improvements in doing that. Do you think there is the possibility for some flexibility and elasticity in this?

Secretary Bowen. As I have stated many times, I am a little prejudiced toward our particular study, because we spent so much time on it. I also admit that there are a lot of alterations which could be made and still meet our general aims. If you increase the coverage, lower the number of deductibles, or lower the $2,000 limit, then the premium is going to have to go up accordingly. We chose the $2,000 cap and the low premium because we thought it was probably the most reasonable and practical balance.

Senator Mikulski. AARP will be presenting about six suggestions later on, and I would really welcome you taking them back to your shop to review and then see if there are those where we could strike a reasonable balance between coverage and premium.

Secretary Bowen. We will be glad to do that when we see them.

Senator Mikulski. I would also, if I could, take the opportunity to return to the conversation about spousal impoverishment. It is an issue in which I have very keen interest, since I am the sponsor of the one of the bills pending before the United States Senate.

In your analysis dealing with catastrophic care, have you done studies on the impact of our current long-term care policies? In other words, do you have any studies on how many people are actually affected by spousal impoverishment; the number of people, particularly women, that have to turn to SSI because they have lost their income and their Social Security benefits were below the poverty line? Have you had a chance to do any work on that?

Secretary Bowen. Not to my knowledge, but I will make an inquiry, and if there have been any studies, we will submit them to you. But there are about 1.4 or 1.5 million in nursing homes at the present time, and we know there are about 500,000 per year who spend down to Medicaid levels, so you could almost judge by those two figures that a considerable percentage of them would have some spousal poverty.

Senator MIKULSKI. I know what the numbers are, but I want you to know what the numbers are and feel a sense of urgency in moving on our legislation. We know that, as you have indicated on page 9 of your testimony, that you intend to do an extensive plan on the long-term care issue.

Secretary BOWEN. Right.

Senator MIKULSKI. And we know it is extremely complex. But the most acute human need right now is the problem of spousal impoverishment. And we feel that this is the session, along with your catastrophic care, to be able to do something about it.

Secretary BOWEN. It would be desirable.

Senator MIKULSKI. Which also takes me to another point, which I do not think would cost much money but would be improved in management. I know that people like yourself and myself believe in self-help, self-reliance and planning. Very often what I find from my constituents is that when catastrophic illness strikes, in long-term care or in acute care, they will say to me, "Senator, I did not know that Medicare did not cover this. Senator, I did not know that Medicare did not cover long-term care." I am sure you are familiar with that from your own community involvement.

What could be done at the Social Security Administration to counsel people when they apply for Social Security to advise them on what Medicare covers, what Medicare does not cover?

Mr. Secretary, when I was a Congresswoman, I held a series of town hall meetings just to brief my constituents on this. I had several hundred people once come out in a snowstorm just to get clarity on this issue.

Could you tell me what plans you have within your own Administration for really telling people, really teaching people, what is covered and where they have to seek, perhaps, private insurance initiatives?

Secretary BOWEN. It is my understanding that about two out of three people of Medicare age do not understand what is covered and what is not covered. This is in spite of the fact that we do present each one with a Medicare booklet when they first get their Social Security coverage that does tell what is covered and what is not covered.

We have taken several steps. For example, in my once-a-week, one-minute radio spots, I have covered that particular subject and will do more. We also are planning to put a stuffer in each of the envelopes that contain the check each month, sometime in the reasonably near future, explaining the benefits.

We are also working with the American Association of Retired Persons [AARP] and other organizations to try to get adequate publicity about what Medicare covers and what it does not. So we are taking many steps to try to correct that situation.

Senator MIKULSKI. Thank you.

Mr. Chairman, let me just conclude by bringing to the Committee's attention a recent study done by our own Office of Technology

Assessment that indicates that Alzheimer's patients are victimized twice. In a recent document called "Losing a Million Minds", they tell us that Federal policies have not been designed to reinforce family and community supports. They talk about how families are bounced around from agency to agency, that often the nursing home costs of Alzheimer's constitutes over $40 billion a years, with $4 billion picked up by the States, $4 billion by the nursing home care under Medicaid, and then the other $32 billion by families of Alzheimer's. And I think that indicates the urgency of really taking a look at long-term care as our next phase in this activity.

The CHAIRMAN. I am delighted that Senator Mikulski mentioned that report. It was issued yesterday by the OTA, and it is about the most comprehensive review, as a result of a three-year study on Alzheimer's Disease, that we have had. And if we look at the impact of dementia on the senior population of our country where, by the year 2000, that report concludes that one out of three seniors will be affected by it, and look at it not only from a health point of view, but what is going to happen in terms of a human tragedy point of view—without even considering the potential financial costs—then we had better start thinking about what our national priorities are going to be if we are really going to be a decent and humane society. Just in that area alone, the flow lines are absolutely mind-boggling in terms of the impact it is going to have on families, on local communities and on State and Federal budgets.

The Senator from Indiana.

Senator QUAYLE. I yield to the Senator from New Hampshire. He has been here for a while—and then I will come back and follow up.

Senator HUMPHREY. Thank you. I thank my colleague.

I was not prepared for such courtesy. I have lost my questions under a pile of paper here.

The CHAIRMAN. Well, once in a while we see that over on that side of the aisle.

Senator HUMPHREY. They are great questions if I can just find them.

Okay. Mr. Secretary, your Chief of Staff, Mr. Burke, was quoted on the Federal Page of the Washington Post on Monday, saying if he was properly quoted, "We are proposing to do it through Medicare because economies of scale and marginal cost pricing for Medicare make it prudent and cost-effective for the Federal Government to provide this added protection."

Now, I would like to have some clarification of the analysis of providing this added insurance through the Federal Government. I would like to know just on what basis Mr. Burke comes to make that statement. I assume that is the opinion, the position, of the Secretary as well, that there are certain economies of scale and cost-effectiveness which make it attractive to offer this added coverage through the Federal Government, versus relying upon the private sector. So I would like to examine that contention. Maybe it is so, but I am a little skeptical, frankly. Let me ask you these questions in that regard.

Do the calculations on which that assumption rests include the full costs of such things as retirement benefits for the personnel who would administer that program?

Mr. Burke. Let me first explain what I said and put it in context. By "marginal cost pricing" we are saying that while there are costs incurred in running the program now—we are still going to have the employees there and we are still going to pay their retirement—there will be no significant add-on cost to the portion of the claim which will cover the catastrophic protection.

Senator Humphrey. Can you answer my question? You do not anticipate having to hire any new personnel, then?

Mr. Burke. We do not anticipate hiring any significant new number of personnel, no. In fact, most of Medicare's claim processing is done in the private sector, so any additional costs that will be incurred will be private sector costs, not public sector costs. We will work through private insurance carriers, who receive about $1 billion a year to administer the program. The economies of scale argument are simple—the larger the risk pool, the better the rate. And there are no medically uninsurable people now in Medicare. Another merit to our proposal is that the elderly have confidence and trust in Medicare; they can identify with Social Security, and we are building on that.

Senator Humphrey. Okay, all right. Try to keep your answers short, Mr. Burke. I do not have that much time.

Well, then, are the costs of farming this out to the private sector factored into your position that the Federal Government is in a better position to offer this than the private sector? Are those costs included in that assumption?

Mr. Burke. In the first year we estimate the administrative costs will be 10 cents per claim because of the initial start-up costs, and each subsequent year it will be about 5 cents per claim.

Senator Humphrey. And the cost of the building space to the extent that that is devoted to this program, and the equipment, is that included in your analysis?

Mr. Burke. Any additional equipment that is needed to process the extra claims is included in those figures. We do not anticipate constructing any new buildings.

Senator Humphrey. You are saying that no new space will be needed in terms of construction or leasing?

Mr. Burke. That is right.

Senator Humphrey. And no significant amount of new equipment?

Mr. Burke. No; I said there will be some additional equipment and that the cost will be amortized in the premium, and it will be 10 cents the first year and 5 cents each subsequent year.

Senator Humphrey. What about the costs of collecting program taxes and premiums, many of which are incurred by other Government agencies and departments? Did you include that in your calculation?

Mr. Burke. I am not sure I understand your question.

Senator Humphrey. I am not sure I do, either, so let us skip it. Staff, give me an example, will you? Do these include the costs of public and Congressional relations activities by Medicare and HHS, your calculations?

Mr. BURKE. No. I was not aware there were any.

Senator HUMPHREY. Well, you have been around long enough to know that there is going to be some element of that involved in this new program, or are you telling us you will get by on existing personnel?

Mr. BURKE. I am telling you, Senator, that we have five fewer people working in our Legislative Office this year than we did last year.

Senator HUMPHREY. And you do not anticipate having to hire any more under this proposal.

Mr. BURKE. I do not anticipate hiring any more under this proposal.

Senator HUMPHREY. Do your calculations take into account the fact that administrative costs for private companies include taxes they pay to the Federal Government, which of course, the Medicare Program does not pay?

Mr. BURKE. That is not a cost to the Federal Government.

Senator HUMPHREY. I know. The Federal Government does not pay taxes. But the question is do your calculations take into consideration the fact that private companies include in their administrative costs taxes paid to the Government?

Mr. BURKE. I do not know how we could factor that in.

Senator HUMPHREY. Well, if you are going to go around making the claim, Mr. Burke, that the Federal Government is better-positioned because of economies of scale and marginal cost pricing as opposed to the private sector, then it seems to me you ought to factor in all of the real costs to the Federal Government in making your comparisons. Don't you agree with that?

Mr. BURKE. I think we have, Senator.

Senator HUMPHREY. But you seem to say you have not made an allowance for the taxes which private insurers pay which are a part of their administrative costs. You are comparing administrative costs, but you are not allowing for the taxes that the private insurers pay.

Mr. BURKE. There would still be taxes paid by the private insurers. The only way they would pay less is if they had a smaller volume of business.

Senator HUMPHREY. But you miss my point. We are talking about cost comparisons. You are saying the Federal Government is more efficient, aren't you?

Mr. BURKE. I am saying these are some costs that are already there, and we are paying only the marginal cost of adding on this benefit. There are not marketing expenses, there are no sales expenses. They are being put into part of a larger program.

The CHAIRMAN. The Senator's time has just about expired.

Senator HUMPHREY. I have a statement for the record, Mr. Chairman.

The CHAIRMAN. Fine. It will be included as part of the record. The Senator from Indiana.

Senator QUAYLE. Thank you, Mr. Chairman.

I welcome my good friend Governor Bowen and apologize to the Chair and to the Secretary for not being here, but I was in a Budget Committee meeting where they are trying to vote out a budget.

The CHAIRMAN. That is good. It has some important increases in allocations for health care, too. We are very grateful, and we are sure you supported that in the Budget Committee. [Laughter.]

Senator QUAYLE. In case you are interested, my vote was "No". I would ask unanimous consent, Mr. Chairman, that my entire statement be included in the record.

The CHAIRMAN. It will be so included.

Senator QUAYLE. Listening to the debate very quickly here and reading the comments that have been made about the Administration's proposal, you get attacked, Mr. Secretary, from the left because it does not cover enough of the general population, or long-term nursing home care. You also get attacked from the right for the fact that you are expanding Medicare and perhaps reversing some of the private sector initiatives in this area.

I think what you have done is set us on a steady course of action where we can deal with a very, very significant problem in our country dealing with catastrophic health care coverage.

We know that there are limitations. But I just want to congratulate you on thinking this thing through, as you do all the time, and coming up with a piece of legislation that is a good beginning, and a beginning that I hope that this Committee and the Ways and Means and the Finance Committees look on as a beginning to discuss this issue.

I think we are going to have to enter into this area with a great deal of caution. I do not think it is something we can hurry up and do just overnight. I know a lot of people would like to do it quicker, and some may not want to do it at all; they just do not think we ought to get into this.

I happen to share the course that you have laid out because I think it is a constructive one, and I hope that there will not be too many detours on it.

I do have some concerns I would like to raise with you. One of the concerns is how do we ensure that there will not be a tendency of overutilization of services, that we will not encourage people to try to get into that category of catastrophic? Are there any mechanisms or devices that you have thought through on how we can perhaps try to prevent this tendency?

Secretary BOWEN. I think one of the biggest controls on the utilization factor would be the DRG program that is in effect now. There is no incentive to remain in the hospital for any longer time than it takes just for the essential care to get the maximum amount of treatment. There is always a danger of increased utilization when you have something being paid for that previously was not covered. But, I do not believe that that is going to be the big problem, simply because of the system that is in effect right now.

Senator QUAYLE. So in other words, you feel its DRG prospective payment system is enough of a tool to deal with this potential problem of overutilization.

Secretary BOWEN. I think that would be one of the deterrents, and of course, the private physician is also one of the means whereby overutilization would not occur. In spite of some of the criticisms, I think that most of the physicians do not desire to overhospitalize and overutilize, and would prefer office visitation rather than hospitalization.

Senator Quayle. A second concern that I have deals with how will we go about educating and informing our senior citizen community on how they will, in fact, convert their Medigap policies to mesh with this plan. I have had people that have told me and members of my staff that it is very difficult to establish an understanding of how this is going to work.

As we begin to pass this proposal, are there any plans from an educational or an informational point of view that HHS intends to implement so these people will be able to have this information? It is not really an easy thing, and unless you have, perhaps, a member of the family that is very astute in dealing with health insurance it could be difficult for many people out there who are trying to mesh their Medigap policies with this plan.

Secretary Bowen. One of the best methods for doing this will be our efforts to work with the senior citizens' organizations through their publications and through their organization people in order to get the information to them. We also will have a stuffer that goes into the envelope which contains their monthly check, which will explain the process and explain what Medicare and Medigap covers and what it does not cover. Also, we will be taking every other means to explain the choices that they have, and I have a little weekly radio program that I can use. We also put out pamphlets, and also in our remarks that we make and in our news releases, we can publicize those choices that are available to them.

Senator Quayle. I just think you will find out—and it sort of goes back to Senator Mikulski's analogy to say what, in fact, Medicare does and does not cover—when we get into some of the practical effects of this, I just can foresee there is going to be a problem—not anything that is insurmountable. There must be a very clearly-defined program in making sure that information gets there.

Mr. Chairman, I see the second bells have rung for our vote. Again, I just want to urge this Committee that what Secretary Bowen has laid forth is something that is not only acceptable, it is something we ought to do. I would just remind our colleagues, though perhaps there are a lot of other things we would like to add to it, there are certain restraints as we plow into some new territory. We are going to have to continue to remind ourselves of this.

Also, I do not know whether I will be able to get back, but Louise Crooks, who is the incoming president of AARP, is also a Hoosier. So you have got me, Bowen and Crooks. I do not know who else you have from Massachusetts——

The Chairman. I think we can count on two out of three supporting this legislation; I am not sure about the third.

Senator Quayle. We will see. Thank you very much, Mr. Chairman.

The Chairman. We want to thank you very much. We will submit some other questions. Thank you very much for coming. We will be working with you.

Senator Adams will be here momentarily and we will continue with Madge Takahashi and Cleo Bowyer, from Salt Lake City.

We will recess now.

[Short recess.]

Senator Adams [presiding]. The Committee will come to order.

The Chairman and I are both extremely interested in all of your testimony. There are back-to-back votes occurring on the Floor, and that is the reason that I left early and that he has moved over to vote now.

Because of the number of witnesses we have, we want to, if possible, invoke the five-minute rule. We do not want to cut anyone off, and we are very grateful that you are here today. So your statements in full will appear in the record and will be a part of the record.

If you wish to summarize them or to read them, whichever you wish is at your pleasure. We welcome both of you here today. We are very grateful that you would come and spend the time. This is the next panel.

Mrs. Takahashi, if you would be kind enough to start, and then Mrs. Bowyer, if you would proceed after that, Senator Hatch will be back in a few minutes, also.

So, Mrs. Takahashi, if you would please start.

STATEMENT OF MADGE TAKAHASHI, BEN-LOMOND, CA, AND CLEO BOWYER, SALT LAKE CITY, UT

Mrs. TAKAHASHI. Senator Adams and Members of the Committee, my name is Madge Takahashi.

I would first like to start with a few adjectives that describe the situation that my parents are in and also many, many other people across the country.

Loss of dignity, pride, and self-worth, and a great deal of fear.

I am here today on behalf of my parents, who are both too ill to travel, to speak with you about the devastating effects of a catastrophic illness. As my parents' primary caregiver and their only child, I have experienced first-hand what catastrophic illness and the resulting medical bills can do to a family.

My parents, who are now in their eighties, are what you and the other members of the Committee would consider to be "model citizens." My father worked until he reached retirement age, first as a jeweler, then for a small lamp company. Both my parents believed in being financially independent. They worked hard, paid their bills on time and raised a family and managed to set aside a substantial savings to carry them through their retirement years.

Like many Americans, my parents planned to spend their retirement debt-free and financially secure. Unfortunately, my parents' retirement plan was drastically altered as a result of a catastrophic illness. Now, instead of living in their own home, they share one room in a local retirement facility. Instead of being financially independent and able to enjoy their retirement, they have been forced to deplete their entire savings to pay for the service not covered by Medicare and must now depend entirely on Medicaid and SSI.

They can no longer afford to take a vacation, buy new clothes, or even go out to dinner. For my parents and many other older Americans, this is demoralizing. These are people who worked hard all their lives and never accepted charity. But now, because of an unforeseen illness and the lack of any kind of catastrophic health care coverage, they have been forced to become totally dependent on public welfare programs.

My parents' case is an excellent example of why the creation of catastrophic health care coverage is so essential. In 1966, my mother suffered her first major heart attack. Since she had not yet reached retirement age, she did not qualify for Medicare. My father, who was nearing retirement age, continued to work so that his employee health insurance would cover some of the costs of my mother's care. In addition to my father's employment health insurance policy, he also carried a small private supplemental insurance policy. Unfortunately, neither policy covered the expense components of my mother's care, such as prescription drugs or capped out-of-pocket expense. This meant that my parents had to pay a substantial portion of my mother's medical expense.

Over the course of the next few years, my mother's condition continued to worsen, and more of my parents' savings were used to cover the cost of her care. In 1978, my father also became ill and required open heart surgery. By this time my parents no longer had a supplemental insurance policy, and their savings had been completely depleted paying for the cost of my mother's care.

Medicare covered a large portion of my father's inpatient care, but my parents could no longer afford the large out-of-pocket expense and had no other choice but to apply for Medical, which is California's version of Medicaid.

Senator, my father is a very proud man and initially refused to apply for Medical. He believed that he should be able to take care of himself and did not want to accept what he considered to be charity. It was extremely painful for both of my parents when they realized that they could no longer afford to take care of themselves and they would have to depend on public assistance. Also, my father now has prostate cancer, and he has had quite a few surgeries.

It can be a very demoralizing experience for an elderly person to be on public assistance. Let me give you an example of what I mean. Shortly after my parents qualified for Medical and SSI, they received a notice in the mail informing them that their cemetery plots would have to be sold. It seemed that the plots were considered to be assets, since they were parcels of land. My parents were warned that unless these assets were liquidated, the value of their land would be subtracted from their monthly SSI check. Fortunately, a recent California statute prevented this from happening.

A similar incident occurred over a life insurance policy which they had to trade in.

I would like to emphasize that my parents are grateful for Medical and SSI. Without it, they would have absolutely no means of paying for their health care or surviving. It is unfortunate, however, that because there is no comprehensive catastrophic health insurance policy, people like my parents have to spend their entire life savings in order to have public assistance cover their medical expenses.

Senator, my parents' case is only one example of the need for comprehensive catastrophic care coverage. Expanding coverage for hospital stays is a beginning, but it is not enough. A catastrophic health care policy must provide some coverage for the real catastrophic expenses—prescription drugs, home care, and long-term care. My parents spent nearly $50,000 to cover this cost.

If comprehensive catastrophic health insurance had been available when my parents first became ill, their lives would be much fuller today. They would still be living in their own apartment, they would be able to pay for their daily chore service that they require, and they would be financially secure and less fearful of their future. Most of all, they would still maintain their dignity.

Thank you very much for this opportunity to testify.

Senator ADAMS. Thank you, Mrs. Takahashi. If you and Mrs. Bowyer will remain at the witness table, I will recess the hearing for 10 minutes, and then we will come back and Mrs. Bowyer, we will hear your testimony, and then we will proceed with the other members of the panel.

So the Committee will stand in recess for 10 minutes.

[Short recess.]

Senator HATCH [presiding]. I wonder if we could call the Committee to order. I have been informed that Senator Adams will return, so I will take the testimony of our witness from Utah as well.

Mrs. Bowyer, let us hear from you at this time. We welcome you here, we are happy to have you here, and we appreciate you helping us in this very interesting set of problems.

Mrs. BOWYER. Thank you.

Senators, ladies and gentlemen, I am Cleo Bowyer, a lifetime resident of Salt Lake City, Utah. I have spent most of my life as a wife and a mother. I never thought I would be discussing this problem of home health care. I never dreamed that I would be involved with a catastrophic health problem. But I am.

My husband is a victim of Alzheimer's Disease and for the past 13 years, I have watched my husband disappear. My husband worked for the Department of Internal Revenue for 35 years, and retired from Government service on December 31, 1974 at the age of 55. We were looking forward to travelling and enjoying his early retirement. We did not have a savings account, but his retirement income was enough for us to make plans. Our children were raised and married; our home was paid for, so we were looking forward to spending time and money on ourselves.

My husband's health was not bad, yet he was having some problems. And it was in October 1975, after a careful physical examination, that we learned he had Alzheimer's Disease.

In the beginning, he tried to work a few little jobs, but his condition worsened, and he was unable to continue. For the next 10 years, I took care of all my husband's needs. Our children helped as they could. They were unable to cope with the emotional stress caused by the changes in their father's behavior. It was difficult for them to see this beloved father change into a person who did not recognize them and who is now unable to talk with them.

My husband's behavior changed radically. He shouted and yelled while I was shaving him and brushing his teeth and doing the various personal grooming one does. For the last 9 months that he was at home, I did have home health care through the Community Nursing Services. A male nurse came in once a week to bathe and to see to his other personal needs. It was a great help to me, and I could not have managed without that help.

When he became incontinent, the struggle to keep him clean and comfortable became an impossible task for me to do at home. In August 1984, we had to place my husband in a nursing home.

Our four children help me when they can. We are a close family, and they give me lots of emotional support, and that helps me. But they have families and homes to care for, and none is wealthy.

Because our income is so high, I am ineligible for property tax abatement or other benefits which would ease the financial burden on me. The cost I am paying for my husband's care is not considered in determining me eligible for any of these programs. Our income this year was about $28,000 from all sources; rent on a downstairs apartment, Government retirement, Social Security, a Veterans Administration disability pension, and the income I can earn from odd jobs—this is almost completely consumed by the cost of my husband's nursing home care and my mortgage payment of $718 a month. Since I do not know what kind of part-time work I will be getting this year, it is difficult for me to project what I will have on a monthly basis.

I am 68 years old, and my secretarial skills have not been used since I was married. Based on last year's income, it looks like I will have about $118 a month for other expenses.

My husband worked for 35 years so that we would have a good pension and a comfortable retirement. We did not realize that it could ever be like this. For the past 13 years, we have been able to manage, but as his illness progresses, I have seen my husband change from a loving person to an invalid who needs constant care. My husband's life is over, and it seems that I am experiencing a long, continuing funeral.

The emotional drain of caring for him and watching him in the condition he is in is taking its toll upon me. Added to this is the strain of constantly being on the brink of financial disaster. If anything goes wrong with the house or with myself, there is absolutely no way I can manage. There is no help for me at all.

I am pleased that the President and Congress have realized that the costs of a catastrophic health condition is unbearable, but the President's plan does not meet the need which I have experienced and which I have seen others dealing with. The real problem for senior citizens—the real issue which we fear—is how to meet the rising costs of nursing home care.

I have told you that I have very little money to meet my own needs. But I am sufficiently concerned about this that I somehow find $38 a month for myself to pay for an insurance policy for nursing home care. I know that no private policy will pay for the kind of expenses my husband is incurring. I feel that I must do something to protect my children from what could happen to me.

I also want to emphasize the importance of home health care. As I mentioned, I could not have continued for the last 9 months my husband was home without help from a nurse once a week. I also badly needed, but could not find, adequate respite care so that I could leave my husband and get away from the continuing 24-hour-a-day care more frequently.

My plea to you is that you expand the President's proposal to include assistance from both nursing home and home health care.

Thank you very much for your attention.

Senator Hatch. Thank you very much, Mrs. Bowyer.

[The prepared statement of Mrs. Bowyer follows:]

STATEMENT OF CLEO BOWYER
SALT LAKE CITY, UTAH

ON THE PROBLEMS OF CATASTROPHIC HEALTH CARE

PREPARED FOR THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

APRIL 8, 1987

Senators, ladies and gentlemen. I am Cleo Bowyer, a lifetime resident of Salt Lake City, Utah. I have spent most of my life as a wife and mother. I never thought I would be discussing this problem of home health care. I never dreamed that I would be involved with a catastrophic health problem. But I am.

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My husband's health was not bad, yet he was having some problem. It was in October 1975, after a careful physical examination, that we learned he had Alzheimer's disease.

In the beginning he tried to work a few little jobs, but his condition worsened and he was unable to continue. For the next ten years I took care of all my husband's needs. Our children helped as they could. They were unable to cope with the emotional stress caused by the changes in their father's behavior. It was difficult for them to see this beloved father change into a person who didn't recognize them and who is now unable to talk with them.

My husband's behavior changed radically. He shouted and yelled when I was shaving him, brushing his teeth, and doing the various personal grooming one does. For the last nine months that he was at home, I did have home-health care through Community Nursing Services. A male nurse came in once a week to bathe and see to his other personal needs. It was a great help to me. I could not have managed without that help.

When he became incontinent, the struggle to keep him clean and comfortable became an impossible task for me to do at home. In August, 1984 we had to place my husband in a nursing home.

Because his civil service retirement income is over twenty thousands dollars a year, we are not eligible for various health care programs. When I realized the expense of his nursing home care, I had to make some decisions about income. I am 68 years old and my secretarial skills have not been used sine I was married. Also, my first priority is my husband - I go to the nursing home once a day to feed my husband his lunch. Therefore, I am not able to get a job which pays very much. So, trying to add to my income, I made an apartment our of our downstairs area. My income from the apartment is $400 a month. I have a $718 monthly payment to pay for the renovation.

Our four children have family and home to care for and none is wealthy. They help me when they can. We are a close family and they give me lots of emotional support and that helps me. I believe that if we had been eligible for home-health care, we would havemanaged without getting into the expense of building the apartment. It is a liability to me, now, and will be until I get it paid off. My personal income is not adequate for me to handle any home repairs. My roof has a leak and damaged the plaster in my bedroom. The house needs painting, as well. I have no money for this work.

Because our income is so high, I am ineligible for property tax abatement or other benefits which would ease the financial burden on me. The cost I am paying for my husband's care is not considered in determining me eligible for any of these programs. Our income this year was $24,516 from the government retirement program. This breaks down to $1,746 dollars a month. I get $145 from my Social Security (my husband's government job was no covered by Social Security). My husband served in the Navy during World War II and receives $195 a month in disability payments from the Veterans' Administration. From this we realized a monthly income of $2,086 last year. I worked in the County Treasurer's office during tax time and earned about $1,192. I also worked in a clothing store and received about $950. So this year we had about $28,596 to live on. This gave me an average monthly income of $2,383 last year.

My expenses for the nursing home last year was $17,288 and it is being increased by $1,200 annually; it will be $19,488 for 1987. My monthly expenses for the nursing home this year will be $1,546 plus the monthly mortgage payment of $718 will mean that I pay out $2,264 a month without having paid the light bill, the heating bill, food, clothing, or health care for myself.

Since I do not know what kind of part-time work I will be getting this year, it is difficult for me to project what I will have for a monthly income. based on last year's income, it looks like I will have about $118 per month for other expenses.

My husband worked for 35 years so that we would have a good pension and a comfortable retirement. We did not realize that it could ever be like this. For the past 13 years we have been able to manage, but as his illness progresses, I have seen my husband change from a loving person to an invalid who needs constant care. My husband's life is over and it seems that I am experiencing a long-continuing funeral.

The emotional drain of caring for him and watching him in the condition he is in is taking its toll upon me. Added to this is the strain of constantly being on the brink of financial disaster. If anything goes wrong with the house or with myself there is absolutely no way that I can manage. there is no help for me at all. I am pleased that the President and Congress has realized that the costs of a catastrophic health condition is unbearable, but the President's plan does not meet the need which I have experienced and which I have seen others dealing with. The real problem for senior citizens - the real issue which we fear - is how to meet the rising costs of nursing home care. I have told you that I have very little money to meet my own needs. But I am sufficiently concerned about this that I somehow find $38 per month for myself to pay for an insurance policy for nursing home care. I know that no private policy will pay for the kind of expenses my husband is incurring; I feel that I must do something to protect my children from what is happening to me.

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My plea to you is that you expand the President's proposal to include assistance for both nursing home and home health care.

Thank you very much for your attention.

Senator HATCH. Mr. Chairman, may I just ask a few questions?

Senator ADAMS [presiding]. Certainly. Mrs. Bowyer, thank you, and Mrs. Takahashi. Senator Hatch has several questions. I want you to know that in my family, we have shared some of the experiences that you have had, and I think your testimony is very eloquent, and we thank you for it.

Mrs. BOWYER. Thank you.

Senator ADAMS. Senator Hatch?

Senator HATCH. Well, I certainly agree, Mr. Chairman. I think you have done this country a great service, coming back here and telling your story.

As I understand it, your husband was first diagnosed as having Alzheimer's Disease about 13 years ago.

Mrs. BOWYER. Yes.

Senator HATCH. And you had to place him in the nursing home about three years ago.

Mrs. BOWYER. Yes.

Senator HATCH. I see. And the cost to you, as I understand it, that you actually have to pay every year comes to about $17,288 per year.

Mrs. BOWYER. That is right.

Senator HATCH. That is $48 per day. And that is going to go up another $1,200 this year.

Mrs. BOWYER. Right.

Senator HATCH. So you are going to be up in the neighborhood of $18,600 per year that you have to pay.

Mrs. BOWYER. Yes.

Senator HATCH. Now, you mentioned insurance costs as a major component of your budget. Do you mean health insurance by that?

Mrs. BOWYER. We have a policy from Blue Cross-Blue Shield, and the cost of that was $1,722 last year.

Senator HATCH. So almost $1,800 a year for Blue Cross and Blue Shield.

Mrs. BOWYER. Yes.

Senator HATCH. I see. And you also have supplemental health insurance, right?

Mrs. BOWYER. Yes. I have the Medicare insurance with my Social Security. This $38 is the amount that I have paid out for a nursing home insurance policy for me.

Senator HATCH. That is for you.

Mrs. BOWYER. Yes.

Senator HATCH. And you are over 65, so you are eligible for Medicare. But do your supplemental Blue Cross policy plus Medicare cover your own medical needs?

Mrs. BOWYER. Not completely. As an example, I am a borderline diabetic. I had a visit with the doctor last month that cost $38. Medicare paid $8, Blue Cross paid $20, and I paid the other $10. With having to pay that extra $10, it can add up.

Senator HATCH. That can really throw you for a loop if you are not expecting to do that.

Mrs. BOWYER. Yes. On a tight budget, you just do not have enough money.

Senator HATCH. Have you ever applied for Medicaid?

Mrs. BOWYER. I have not applied, but I have investigated it, and I am not eligible.

Senator HATCH. Does Medicare or Medicaid or any of your private insurance pay for any part of your husband's care in the nursing home?

Mrs. BOWYER. None at all.

Senator HATCH. Not one penny.

Mrs. BOWYER. Not a penny.

Senator HATCH. So you are having to do all that by what money you have coming in.

Mrs. BOWYER. Right.

Senator HATCH. As I understand it, you have a total a year of about $28,000 when you count your pension, your Social Security, and your husband's veterans disability benefit; and then you work as well.

Mrs. BOWYER. Odd jobs, seasonable jobs.

Senator HATCH. And the nursing home will be about $19,000 of that; your home mortgage is about $8,000 of that; so you are talking about $27,000 of the $28,000 that basically go to support your husband in the nursing home and pay off the mortgage on your house.

Mrs. BOWYER. Right.

Senator HATCH. That leaves you virtually nothing to get by on.

Mrs. BOWYER. There is not much left for the lights and the heat.

Senator HATCH. Well, in fact, you said that you would only have about $118 per month next year for expenses not pertaining to your husband's nursing home care or your mortgage. But it looks to me like that $118 per month will be exceeded by your monthly cost of Blue Cross-Blue Shield; is that right, if you want to continue to maintain that for yourself?

Mrs. BOWYER. That is correct.

Senator HATCH. And then add to that the $38 per month that you have for your own nursing home policy that you have taken out on yourself.

Mrs. BOWYER. Yes.

Senator HATCH. The question arises to me as to how do you pay your light bill, how do you pay your heat bill, how do you pay for your food?

Mrs. BOWYER. Sometimes, I do not. Sometimes, I do not pay all of the nursing home care. Sometimes, I cannot pay that full amount. Then it becomes a problem of catch-up. I get a seasonal job, I get extra work, in order to try and meet those payments and try to pay the nursing home.

Senator HATCH. If you had your way, what would you have this Committee do to help you and others like you?

Mrs. BOWYER. I would have them expand the program so they would give us help on nursing homes and the home health care, if they could expand it to where we could get help on the nursing home so it would not be so devastating, and also to expand it for the home health care. As I said, I had nine months I kept him home, with the help of a nurse coming in.

Senator HATCH. Well, I am in agreement with you. I think something has to be done. We hope the bill that we filed will go a long way toward doing that. We have some of the best people in the world testifying on home care before this hearing is over. And I am hopeful that we can do some things in this area that will alleviate some of your frustration, your pain, and the expense that you have to incur.

So we will do everything we can to try and resolve this, and I am hopeful that this Congress will come up with a good resolution. I think this Committee will, and I will do everything in my power to help you.

Mrs. BOWYER. Thank you, Senator.

Senator HATCH. Thank you for being here. We really appreciate your testimony.

Senator ADAMS. Mrs. Takahashi, is there anything that you would like to add, having heard the testimony of Mrs. Bowyer and the other witnesses?

Mrs. TAKAHASHI. Yes, I would. There was some mention here today about the way the Administration feels about family help, that the family could help in catastrophic illnesses. And I, being a daughter of parents who are catastrophically ill, I would love to be able to help my parents. But we do not have thousands and thousands of dollars extra to give my parents every year. And if I help them a little, I have to help them secretly, because they would take them off Medicaid, because then they would get too much money.

So it puts children in a bind, also, and you feel very guilty. We are put into a situation where if we do help them, we are doing something illegal; if we do not help them, we are doing something immoral.

Senator HATCH. Good point.

Senator ADAMS. Thank you, Mrs. Takahashi, thank you, Mrs. Bowyer, we appreciate the testimony of both of you very much.

I would now like to call forward Panel 4: Jacob Clayman, Louise Crooks, Judith Feder, James Moorefield, and Philip Brickner.

The Committee wants to welcome all of you here today. We appreciate very much your taking the time to be here. The Chair will state that we hope that the witnesses will summarize their statements, but your entire statement will be included in full in the record so that we will have that information. And if you can summarize, we would appreciate it, because that will leave more time for questions and for potential give and take in the panel. We regret that, as always, the Senate schedules are very pressed, and we appreciate your having been willing to come and to help us with this problem. The Committee wishes to move on this bill as promptly as possible. That is one reason we are moving through lunch and everything to complete the hearings.

Mr. Clayman, why don't you start as the first witness?

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC; LOUISE CROOKS, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC; DR. JUDITH FEDER, CO-DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE, WASHINGTON, DC; JAMES L. MOOREFIELD, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC; AND DR. PHILIP BRICKNER, DIRECTOR, DEPARTMENT OF COMMUNITY MEDICINE, ST. VINCENT HOSPITAL AND MEDICAL CENTER OF NEW YORK, NEW YORK, NY

Mr. Clayman. Mr. Chairman, I am traveling under a fraudulent disguise. I am not a "doctor", and so let the record show that I do not speak professionally as a doctor.

Senator Adams. They put "doctor" instead of "J.D.", Jake, and I am sorry about that.

Mr. Clayman. All right. Very good.

I am pleased to be here on this important issue, and it is good that we have an airing of this problem. The two people who preceded us made the most eloquent case I have heard for a long time for our Government to get involved in the health care of its people. And the fact that we do not become more involved as I listen to these two almost makes me feel that we are immoral for our failures, for our shortcomings, and indeed often for our indifference.

Well, let me read my statement quickly, or a portion of it.

Catastrophic costs look very different for the elderly than they do for the rest of the population. The elderly are faced with three types of catastrophic costs—costs associated with the need for long-term care, out-of-pocket costs associated with both covered and uncovered health services, but particularly associated with the high cost of prescription drugs, and catastrophic costs associated with long-term hospitalization where neither Medicaid nor Medgap offer protection.

Unfortunately, the Administration's plan would not adequately address any of these crucial catastrophic health events faced by older Americans. The National Council of Senior Citizens has specific suggestions to make on how we might provide coverage for each of these types of catastrophic costs. Although the long-term care issue presents financing problems which the Congress may not feel ready to address, there are concrete steps that can be taken to make long-term care more accessible and less catastrophic for the elderly.

Specifically, the three-day prior hospitalization requirement for Medicare-covered skilled nursing care should be eliminated along with all Medicare SNF copayments, a remedy to the problem of spousal impoverishment which you have just heard so eloquently and sadly a few minutes ago, should be made an integral part of a catastrophic package. And the Medicare home health benefit should be more clearly defined.

To address the need for first dollar coverage for the poor and near-poor, States should be required through the Medicaid program and possibly with an enhanced Federal match to cover Medicare cost-sharing requirements and provide prescription drug coverage to all seniors below the Federal poverty line.

We believe there is also ample justification for the inclusion of a prescription drug benefit for the Medicare population. These costs have risen dramatically, and there is little insurance protection available.

Moreover, there would be some offsetting savings to a Medicare program by offering such coverage. A lower catastrophic cap would help us achieve the goal of increased coverage for out-of-pocket costs for the elderly. We recommend as well that excess physician charges and prescription drug costs also be included to cover the cap.

These additional benefits should be paid for through a variety of mechanisms. Hospital payment rates under DRGs should be rebased, and the savings should be used to finance part of this package. That is possible and achievable, in my judgment.

State and local employees should be brought under Medicare using the resulting additional revenues to pay for this catastrophic coverage, and the elderly should contribute to benefit financing through a more progressive financing mechanism.

For six years now, the window of opportunity to improve and humanize Medicare has been tightly closed. But we now sense a new mood in Congress. The window of opportunity is slightly ajar. We must not waste this precious chance to make some meaningful reform in our Medicare health system. Let us seize the moment. And when I say that, I fully appreciate that both the temporary Chairman and the permanent Chairman of this Committee will be willing to seize that moment, and that gives me hope, it gives us hope, and it should give these two people who appeared before you just a few minutes ago hope, also.

[The prepared statement of Mr. Clayman follows:]

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CATASTROPHIC HEALTH CARE and the ELDERY

Testimony Presented Before the Senate Labor and Human Resources Committee

By

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April 8, 1987

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Thank you, Mr. Chairman, for holding this important hearing on catastrophic health care. You are certainly to be commended for your leadership in this extremely important issue and we look forward to working with you.

Catastrophic health care coverage is a very important issue, but it is not a new one, as you well know. In the 20 years that we have been discussing catastrophic illnesses and how to pay for them, we have always ended up with another study which lasts for a year and then is forgotten. We are now faced with a window of opportunity to make genuine improvements in Medicare, the likes of which we have not seen for many years--and may not see for many more.

Catastrophic costs generally look very different for the elderly than they do for the rest of the population. The elderly face three types of catastrophic costs: costs associated with the need for long-term care; out-of-pocket costs associated with both covered and uncovered health services, but particularly with the high cost of prescription drugs for middle- and low-income people; and, catastrophic costs associated with long-term hospitalization where neither Medicaid nor Medigap offers protection. Unfortunately, the Administration's plan would not adequately address any of these crucial catastrophic health costs faced by older Americans.

One of the single greatest catastrophic events an older American can face, both emotionally and financially, is being placed in a nursing home. Nursing home costs average $22,000 per year. Altogether, the elderly, in 1986, spent out of their own pockets $37.3 billion on health care, $16 billion of which was spent on nursing homes alone. In this way, 1.6 million of the nation's elderly spent $16 billion--fully one-half of the nation's total nursing home bill--out of their own pockets.

This is an enormous burden that the elderly and their families are forced to shoulder themselves. While most of the elderly think the Medicare program or their Medigap policies will help with these costs, this couldn't be much farther from the truth. Medicare expenditures for care in skilled nursing facilities equal only two percent of total national nursing home expenditures, and only one percent of the total Medicare budget. Similarly, private insurance covers only one percent of the nation's nursing home bill. The grim reality that many elderly are forced to face is that protection from these tremendous costs does not exist until they have spent themselves into poverty.

In our opinion, continuing reliance on a public policy that withholds health care protection until and unless hard-working citizens pauperize themselves is not something in which we can take pride. Clearly, faced with the problem in both financial and human costs, we need to find a more rational, well-coordinated approach to covering the catastrophic health care costs associated with the need for long-term care.

The National Council of Senior Citizens understands the realities of Gramm-Rudman-Hollings and the chilling effect the Federal deficit has on good public policy generally, and good health care policy specifically, and so we realize that comprehensive coverage of long-term care costs within a public health program may not occur as soon as we would like. Intermediate steps can be taken in this area, however, and other very serious catastrophic costs faced by the elderly certainly can and should be included in a catastrophic package that aims to provide useful protections for the elderly.

Besides the obvious and tremendous costs of long-term care, Medicare cost-sharing and out-of-pocket costs, especially for prescription drugs, are catastrophic for many older Americans. The elderly today spend the same proportion of their incomes on health care as they did before Medicare and Medicaid were created in 1965. In 1984, average out-of-pocket health care costs for the elderly accounted for 15 percent of their incomes, the same level that existed before Medicare was enacted. Not including nursing home and other long-term care expenses, the average annual out-of-pocket health expenses for the elderly reached $1,055 in 1984, more than three times the average amount ($310) spent by other Americans.

The elderly are financially liable, under the Medicare program, for many out-of-pocket costs associated with Medicare covered services, including premiums, co-insurance charges, deductibles and costs above the Medicare "reasonable" charge limit. These costs have soared in recent years, leaving the beneficiaries with ever-heavier financial burdens to bear. The Part A hospital deductible, for example, increased by 155 percent in the past six years, from $204 in 1981 to $520 in 1987--an increase five times as great as the overall rate of inflation. The annual Part B premium for physician and other costs has increased by 86.5 percent in six years, from $115.20 in 1981 to $214.80 in 1987, and out-of-pocket costs for physician charges above the Medicare "reasonable" charge limit increased 286 percent, since 1977, to $2.7 billion a year.

In addition to these costs for covered services, the elderly paid $7 billion out of pocket in 1981 for many vital health care needs not covered by Medicare, including prescription drugs, eyeglasses, hearing aids, dental care and physical examinations. For 75 percent of the elderly population, prescription drugs represent the largest out-of-pocket expenses they will face. Many elderly individuals take four to five drugs a day and, on average, fill at least 12 prescriptions every year. In fact, while people over age 65 represent only 12 percent of the population, they take 30 percent of all prescription drugs used in this country. Unfortunately, unlike most other health care costs, prescription drug costs are not covered by private health insurance or by Medicare out of the hospital. Medicaid will only cover the costs of prescription drugs for the indigent, or about six percent of the elderly's total drug expenditures. Only 20 percent of the elderly fall into one of these categories, leaving the remaining 80 percent to pay for these drugs out of their own pockets.

These costs are far from insignificant. The elderly's drug bill amounts to over $6 billion annually. Payments for drugs represent 20 percent of the elderly's total out-of-pocket health care costs and average $340 per person per year.

The extraordinarily high rate of inflation, and high rates of profit, in the prescription drug industry, are, in large part, accountable for the increased financial burden borne by the elderly in trying to pay for these costs. Last year, while medical care costs overall rose 7.7 percent, seven times as fast as the CPI, prices for prescription drugs outpaced all other medical costs by rising nine percent. Tranquilizers and sedatives, which are often prescribed for older people, posted the biggest price increase of 13.2 percent. At the same time, pharmaceutical corporations, in 1984, enjoyed profits of 13.2 cents on the dollar, compared to 4.6 cents for all manufacturers, in fact, profits in this industry have traditionally outpaced the average profit for all other industries by two and even three times.

For elderly people not eligible for Medicaid, but too poor to purchase a Medigap policy, staggering health care costs have become overly burdensome. Nearly 2.2 million seniors living below the Federal poverty line ($5,156 in 1985)--only 36 percent of the low-income elderly--are covered by Medicaid. Another 6.2 million near-poor seniors whose incomes are less than twice the Federal poverty line are also not covered by Medicaid. These seniors, who are the sickest and poorest, are exposed to health care costs equal to one-fourth to one-third of their income, or about $1,300 per year.

First-dollar coverage for the health care costs of this population is especially important since this group is much sicker than other elderly. Death rates are 50 percent higher than for all Medicare beneficiaries. But, despite their greater health needs, they receive 35 percent fewer physician visits, 29 percent fewer prescription drugs and are 18 percent less likely to be admitted to a hospital.

Typical out-of-pocket costs for a moderate spell of illness for a senior whose income is lower than the Federal poverty line, but is not low enough to quality for Medicare, can be catastrophic in the extreme.

Medicare Part A deductible = $520.00
Medicare Part B premium = $214.80
Medicare Part B deductible for physician services = $75.00, more if the physician does not accept Medicare assignment
Medicare Part B co-insurance on a physician bill of $2,575.00 = $500.00
Prescription drug bills = $500.00
Bills for eyeglasses, dental care, etc. = $250.00

Total typical health care costs equal $2,003, out of an income below $5,156.

At this rate, the poor and near-poor elderly could not realistically be expected to pay an additional premium for catastrophic protection and out-of-pocket health care costs to reach a cap, such as the one proposed by the President. This group of very vulnerable and financially depressed seniors needs protection long before the cap is reached. The idea behind catastrophic protection should be to enable citizens to avoid being wiped out financially before protection begins. For these seniors, even ordinary out-of-pocket costs would cause them to be wiped out, or more likely, to avoid getting needed health care altogether.

Finally, there is the issue of the cap itself. According to the figures we have seen, an estimated 96 percent of older people will never reach the $2,000 cap proposed under the Administration's plan.

The National Council of Senior Citizens has specific suggestions to make on how we might provide coverage for the three types of catastrophic costs faced by this nation's elderly: 1) coverage of long-term care costs; 2) providing first-dollar protection for low and lower income elderly, as well as covering the costs of prescription drugs; and 3) expanding the population assisted by the catastrophic cap.

Although the long-term care issue presents dramatic financing problems that the Congress may not be ready to address, there are concrete steps that can be taken to make long-term care more accessible and less catastrophic for the elderly. Specifically, the three-day prior hospitalization requirement for Medicare-covered skilled nursing care should be eliminated, along with all Medicare skilled nursing facility co-payments; a remedy to the problem of spousal impoverishment should be made an integral part of a catastrophic package; and the Medicare home health care benefit should be more clearly defined.

To address the need for first-dollar health care coverage for the poor and the near poor, states should be required, through the Medicaid program and possibly with an enhanced Federal match, to cover Medicare cost-sharing requirements and provide prescription drug coverage to all seniors below the Federal poverty line. Medicaid coverage of these costs would provide payment of all deductibles, premiums and co-insurance amounts required by the Medicare program. It would also entitle beneficiaries to physician services through assignment and would provide adequate coverage of prescription drugs costs for this very poor segment of our society. Congress should also explore the possibility of an optional "buy-in" to Medicaid for people over the age of 65.

In addition, Mr. Chairman, we believe there is ample justification for the inclusion of a prescription drug benefit for the general Medicare population. As we have said, these costs have risen dramatically and there is little insurance protection available. Moreover, we believe that there would be some offsetting savings to the Medicare program by offering such coverage.

In a soon-to-be released study performed by the Department of Pharmacy Practice of the University of South Carolina, it was found that, after the State of New Jersey implemented its Pharmaceutical Assistance to the Aged program (PAA), Medicare recipients had, on average, $238.50 less in in-patient hospital costs than had a comparable group in Pennsylvania where no program was offered. The study also showed that hospital lengths of stay could be reduced by offering a prescription drug program. One of the study's conclusions was that "it appears that savings in reduced hospital stays are greater than or equal to the expenditures for prescription reimbursements plus the program's administration costs."

The New Jersey program requires a $2.00 co-payment and links reimbursement to the Maximum Allowable Cost (MAC) system under Medicaid. We would suggest a benefit for older people that would require a $1.00 co-pay and a $200 deductible. The cost of such a program would be between $1.6 billion and $2 billion--about the same amount that would be raised through the coverage for state and local employees under Medicare.

Mr. Chairman, over the past 20 years, 436 bills have been introduced in Congress to cover prescription drugs and still no action has been taken. As a result, although at least nine states have enacted plans, older people in 41 states still have no assistance. Our senior citizens have been calling for prescription drug coverage long and loud over this period of time and I hope you will act to include such a benefit in your legislation.

A lower catastrophic protection cap than the $2,000 level proposed by the Administration would help us achieve the goal of increased coverage for out-of-pocket costs for the rest of the elderly population. NCSC recommends that excess physician charges and prescription drug costs also be included to reach the cap. By not including these high-cost items, the cap would ignore a very significant portion of the elderly's health care costs.

As always, it's a lot easier to talk about what benefits should be provided under a public health care program than it is to determine who should pay for the added benefits. But, in this case, I think the answer is a fairly simple one--the burden should be shared. It is vital to keep in mind, as we discuss health policy and its effect on the deficit, that, since 1980, domestic programs serving the poor and the elderly have sustained deep cuts, even as citizens have suffered increased costs while receiving less than at the deficit has grown. As a result, many of our most vulnerable any time in recent history. The Medicare program's cuts already adopted will cost Medicare beneficiaries $14 billion over the next five years.

Clearly, the elderly did not cause our current budget deficit. The Congressional Budget Office (CBO) recently found that, if the budget and tax policies that were in effect when the Reagan Administration took office had been continued, rather than changed, the Federal deficit in FY 1985 would have been $80 billion (about the same as in 1981) rather than the $212 billion level at which the deficit now stands. The changes in defense and tax policy, along with the increase in interest payments on the national debt, caused by these policies, added $167 billion to the Federal deficit in 1985, meanwhile, domestic cuts--including reductions in Social Security, Medicare and Medicaid--reduced the deficit by $38 billion. The net result was an increase in the deficit of about $130 billion.

Let's keep in mind, then, that the elderly have done more than their fair share in being fiscally responsible and helping to reduce the Federal deficit. They have taken the cuts on the chin and in their wallets for seven years now and have asked for little in return.

There are, however, very real savings that can and should be found through the providers of health care in our country and, in fairness, savings from these cuts should be targeted to pay, at least in part, for any Medicare coverage expansion.

The NCSC urges the Committee to consider the possibility of rebasing the DRGs to factor in more current cost and efficiency data and using the resulting savings, which CBO estimates at $4.4 billion in the first year, to help finance new benefits for the elderly. Hospitals, under PPS, are still being paid based on 1981 cost data, even though significant cost and efficiency savings have resulted since implementation of PPS. In addition, some services formerly provided primarily on an in-patient basis, and included in the 1981 rates, are now provided in out-patient settings, or SNFs, where they are separately reimbursed on a reasonable cost basis. Lower, more accurate reimbursement rates would avoid what is, in effect, double payment for these services.

Nineteen eighty-four data is currently available on which DRG payment rates can be based. We firmly believe such action is warranted and fair, and that the resulting savings should be plowed back into the Medicare program.

Physicians should also be included in the finance design. Inclusion of hospital-based physicians' services in the PPS payments would raise $70 million in FY 1988, $170 million in FY 1989, and $240 million in FY 1990, for an impressive three-year total of $480 million.

NCSC recognizes that the elderly should participate in financing any kind of comprehensive benefit expansion. We believe the elderly's share should be progressively financed and should not overburden the poor, although we do not support taxing the actuarial value of the Medicare benefit. The Administration's proposal, with its reliance on a flat premium for all beneficiaries, runs the very real risk of increasing the burden on all beneficiaries in order to better protect only a few. The Administration's high cap, plus the additional premium, would place a much greater proportional burden on low- and middle-income beneficiaries, while it would hardly make a dent in the assets of a few. For these reasons, a progressive approach to beneficiary participation, with special allowances for the poor and the near poor, is vital to providing catastrophic protection for all elderly.

In addition, NCSC advocates the inclusion of state and local employees under the Medicare program. Since the majority of these citizens eventually rely on the benefits and protections provided by the Medicare program, we believe it is entirely fair that they also be required to take part in the financing of the program. Revenues generated by the proposal should be used to at least partially finance the Medicare benefit improvement under a catastrophic provision.

In conclusion, let me just make mention of a very important public service of which the elderly are sorely in need.

A separate, serious problem facing the elderly, that we all have a grave responsibility to address, is the issue of breaking the news to the elderly of America that the public programs they've relied on, and that they may rely on in the future, do not cover long-term care. I am very concerned, Mr. Chairman, that the public at large, but seniors especially, are being given a very false sense of security in thinking that the Administration's plan will provide for the costs of long-term care.

Already, a large portion of the Medicare population believes the Medicare program provides long-term care coverage--a belief they've been allowed to keep for far too long. Now, just as they're beginning to hear that this may not be the case, the Administration is holding out a new plan that, in the words of the President, will "give Americans that last full measure of security."

The greatest financial fear of many older Americans is the spectre of nursing home care and the last full measure of security they can be given is protection from the costs of long-term care. The President's comments, I greatly fear, will only cause seniors to shift from one false hope of relying on the Medicare program to answer these needs to another of relying on the catastrophic plan that the Administration has proposed.

I think it's very important that we go forward with a Medicare improvement plan, but I feel very strongly that it is incumbent upon all of us involved in shaping this public policy that we are very clear in describing just what the plan will--and won't--do for prospective beneficiaries. It would, in our opinion, be absolutely unconscionable if we were at all misleading. If the plan would not include long-term care benefits, that message needs to get across. NCSC will do its part in trying to ensure that Medicare beneficiaries and their families have factual, full information on which to base their decisions on planning for future needs. Medicare beneficiaries must not be lulled into a pleasant, but erroneous, belief that their long-term care needs will be met by paying $4.92 a month more in Medicare premiums.

Finally, we must not fail to recognize the fact that the plans under discussion deal only with the elderly population. NCSC recognizes and sympathizes with the plight of 37 million younger Americans who have no health insurance at all. Catastrophes affect people of all ages and something must be done to help these people as well. Mandating employers to provide health insurance is one step. But, we should also consider requiring states to provide Medicaid coverage to all those below the poverty line. A major step was taken in this direction in the last Congress and we must continue to press for such a Medicaid expansion.

Thank you, again, Mr. Chairman, for the opportunity to testify and present our views on the need for catastrophic health care protection this morning. Your leadership is invaluable to the senior citizens of this nation. We hope our suggestions have been helpful and we sincerely hope you will continue to call on us in the future as we look for compassionate, reasonable solutions to the problems facing the elderly.

Senator ADAMS. Thank you, Mr. Clayman, very much.

I have just one question, and then I want to go to Ms. Crooks. Would you support passage of the Bowen plan if it came up for a vote on the Senate Floor in its present form?

Mr. CLAYMAN. The answer is no.

Senator ADAMS. Ms. Crooks?

Ms. CROOKS. Thank you, Senator Adams.

On behalf of the more than 24 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the problems of catastrophic illness.

The Association commends you and your colleagues for your interest in developing a catastrophic illness plan for older Americans. I will focus my remarks today on four areas—the first, the major source of catastrophic costs for older Americans; second, acute care costs; third, the Association's response to the Administration's catastrophic proposal, and fourth, the Association's own recommendations.

Undisputedly, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term care, as we have just heard.

As our first chart indicates, nursing home stays account for 80 percent of the expenses incurred by older people who experience very high out-of-pocket medical costs. For most older Americans, acute care illness is less likely than long-term illness to result in a catastrophic burden. But Medicare's coverage of acute care is by no means complete. Beneficiaries must pay deductibles and coinsurance for Medicare-covered services, and must bear the full weight of the costs of non-covered medical services and goods.

About 70 percent of enrollees purchase private supplemental insurance plans to protect themselves from the gaps of Medicare insurance. But there is great variability in the coverage offered by such plans. They seldom provide protection against the costs of prescription drugs, balanced billing by physicians, dental, optical, and eye care, and again, nursing home care.

Further, their cost in premiums may be high, relative to the benefit returned to the insured. In addition, there is a growing need for home health care as beneficiaries are discharged from hospitals sooner.

It is reassuring to believe that the Medicaid program will protect elderly people from catastrophic acute care costs. But this is not the case. In 1986, only 27 percent of elderly people with family incomes under $5,000 were covered by Medicaid.

Now, who among the elderly are most vulnerable to acute care catastrophic costs? The answer must include the 21 percent of Medicare beneficiaries whose insurance protection is not supplemented by Medigap or Medicaid.

As our second chart shows, these individuals tend to be very old; they are poor, and they are frail. And another group of particular concern is the 44 percent of the poor, elderly Americans who feel compelled to buy Medigap insurance, but who surely must forgo certain day-to-day essentials in order to do so. And we have just heard an example of that.

Secretary Bowen's catastrophic proposal represented an important first step in the development of a viable plan to protect Medicare beneficiaries from acute care catastrophic costs. But his proposal, which is now the Administration's proposal, is a minimal one. Its $2,000 cap on coinsurance and deductibles would hardly protect an elderly person of limited means from financial catastrophe.

Further, the plan offers no protection for extended nursing home care, prescription drugs, balance billing and vision and hearing care. The Administration's proposal may strengthen Medicare, but it is misleading, I think, to label it a catastrophic protection plan.

The Association advocates the development of a benefit improvement that incorporates a catastrophic cap that is more comprehensive than the Administration plan. Our proposal better balances the need for acute care protections with the need for long-term care protections. It also includes critical protections for low-income beneficiaries.

Our package consists of three parts. First, our acute care proposals include one hospital deductible per year; the elimination of hospital coinsurance and lifetime limits; a $1,000 cap on Medicare Part B cost-sharing; a prescription drug benefit, and Medicaid improvements which we view as inseparable from the cap.

For transitional care, we recommend improvements in the skilled nursing facility and the home health benefit as well as a new respite benefit.

And third, our long-term care component would include protection against spousal impoverishment and expansion of home and community-based services.

To pay for these improvements, we recommend an assortment of financing sources: doubling the tobacco tax; extension of health insurance coverage to State and local workers, and an increase in the Part B premium.

The proposal to finance the catastrophic plan by taxing the actuarial value of Medicare represents a radical departure from existing financing mechanisms. While we encourage the exploration of innovative improvements, we also are not convinced that a modest benefit package justifies such an approach. We believe that other financing options should be exhausted first.

And I think we must always remember that we must comfort the people in our country, and this is a very pressing social need.

I thank you.

[The prepared statement of Ms. Crooks, with attachments, follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE

Presented by:
Louise Crooks, President-Elect

before the

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

April 8, 1987

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
John T. Denning *President* Cyril F. Brickfield *Executive Director*

Thank you, Chairman Kennedy. On behalf of the more than 24 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the problem of catastrophic illness.

Before I begin, however, I would like to say that the Association is gratified by the current congressional and public interest in the problem of high cost illness and its impact on the citizens of this country. We believe that the public debate on catastrophic illness will lead to a more complete and more accurate understanding of the problem; the debate itself is, in our view, a critical step in the development of workable, appropriate solutions to a complex but hardly intractable social problem.

Let me say, at the outset, that the Association commends Chairman Kennedy and the members of this committee for your work towards the development of catastrophic health protection for the American public.

I will focus my remarks this morning on four areas: the major source of catastrophic costs for older Americans; the nature of the acute care catastrophic experience among older Americans; proposals by the Administration and Congress to address elements of the catastrophic problem; and finally, recommendations by the Association, building in part upon the work of Secretary Bowen, and proposals emerging from the Senate and the House.

THE MAJOR SOURCE OF CATASTROPHIC COSTS FOR OLDER AMERICANS

Let us be clear this morning about the source of catastrophic costs for this country's senior citizens. Indisputably, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term, chronic illness. As Chart 1 indicates, nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year).

The need for long-term care leads almost inevitably to an unmanageable financial burden because the costs of care--be it in an institution or in the home--are often enormous. Chart 2 shows the amount that an individual would pay for a 12-month stay in a nursing home and for modest medical expenses during that year. At more than $20,000 each year, few families could survive such expenses without severe financial hardship. Medicare and private insurance combined pay only a miniscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid, a means-tested welfare program. To qualify for Medicaid, one must either be poor or reduced to poverty in the process of trying to pay for care.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Fully one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately 2/3 of single older persons and 1/3 of older couples in Massachusetts were impoverished after only 13 weeks in a nursing home.

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must often spend-down their combined income and assets, leaving one spouse--usually the wife--destitute. Many of the same women who are caught in the spend-down problem have spent years taking care of ill and disabled husbands at home.

Personal care services of indefinite duration in the home are not covered at all by Medicare, and the amount and type of home care provided under Medicaid is extremely limited in most states. Even those who can afford to pay for home health and other in-home services face often insurmountable barriers in locating competent, trained personnel. As a result of both limited access to home care and the very high expense of nursing home care, many older persons live in fear of becoming a burden on their families, or being forced to enter a nursing home and spend their lifetime savings in order to pay for care.

THE ACUTE CARE CATASTROPHIC EXPERIENCE AMONG OLDER AMERICANS

For older Americans who have Medicare coverage, an acute care illness is less likely to result in a catastrophic burden than a long-term illness. But Medicare's coverage of acute care is by no means without significant gaps, gaps which if not supplemented by other forms of insurance, leave individuals vulnerable to devastating medical costs. Chart 2 shows that a Medicare beneficiary with two hospital stays would, on average, incur out-of-pocket expenses that would total nearly $3000 without private supplemental insurance and would even result in expenses over $1600 with an average insurance policy.

Medicare beneficiaries' liability for acute care medical costs consists of two components: (1) Medicare cost-sharing requirements (i.e., deductibles and coinsurance) for covered services, and (2) expenditures for non-covered medical services and goods. It is important to distinguish between these two categories of liability since most of the catastrophic "cap" plans that have been proposed permit the former (coinsurance and deductible amounts) to be counted toward the cap but exclude the latter (expenditures for non-covered services and goods). And the second category of liability is by no means insignificant; we estimate that, on average, for every $1.00 beneficiaries incur in coinsurance and deductibles, they spend an additional $.50 to $1.00 for non-covered services and goods.

1. Deductible and Coinsurance Liability

Under *Medicare Part A,* beneficiaries are required to pay a hospital deductible in each benefit period approximately equal to the cost of one day of hospital care ($520 in 1987). They are also responsible for coinsurance for days 61 through 90 equal to one-fourth of the hospital deductible. For each lifetime reserve day (days 91 through 150), beneficiaries are required to pay an amount equal to one-half the Part A deductible, or $260 per day in 1987. While there is no deductible for skilled nursing facility (SNF) services, Medicare beneficiaries this year will pay $65 per day to satisfy coinsurance requirements for days 21 through 100 in a SNF.

Approximately 23% of Medicare enrollees are admitted to a hospital at least once in a given year. But only about .5% of Medicare enrollees (158,000 in 1984) use more than 60 hospital days in a year, thereby triggering hospital coinsurance requirements.

In 1985, Medicare beneficiaries incurred $3.2 billion in Medicare hospital deductible and coinsurance liability. This amount represented an increase in such aggregate liability of more than 100% between 1980 and 1985. The largest portion of total Part A cost-sharing liability is attributable to the Part A hospital deductible.

Beneficiaries also share heavily in the cost of Medicare Part B services. Each beneficiary must meet a $75 annual Part B deductible, and is also responsible for 20% of the amount that Medicare deems "reasonable" for a particular Part B service. (In addition, beneficiaries whose doctors do not accept assignment are fully responsible for the amount their doctor charges above the Medicare-approved rate.)

Cost-sharing requirements under Medicare Part B represent a far greater financial burden on Medicare beneficiaries than do cost-sharing requirements under Part A. In 1986, Medicare beneficiaries incurred $5.7 billion dollars in Part B coinsurance liability and $1.7 billion dollars in Part B deductible liability. The most striking rate of increase in physician-related liability has occurred in coinsurance liability which in the aggregate has risen by 170% since 1980. Moreover, increases in Part B coinsurance expenditures have far outpaced increases in Social Security benefits.

Whereas only about one-fourth of Medicare beneficiaries will incur liability from the use of hospital services in a given year, 80% will incur liability from the use of physician services during the same period. Further only .5% of beneficiaries will trigger hospital coinsurance costs, but fully 60% of beneficiaries will incur coinsurance liability for physician services.

2. Medical Services Not Covered by Medicare

In addition to Medicare's cost-sharing requirements for covered services, beneficiaries also face significant out-of-pocket costs for those acute care medical services and goods which Medicare does not cover or which, in the case of certain services, are subject to Medicare's durational limits.

These acute care services include:

- Balance billing by physicians on non-assigned claims

- Dental services/products

- Optical services/products
- Hearing care services/products
- Routine physician examinations, influenza shots, Pap smears.

Out-of-pocket expenditures for these non-covered acute care services can be staggering: almost $3 billion for balance billing by physicians; more than $2.3 billion for dental care; and more than $1.4 billion for eye care.

3. Prescription Drugs

In addition, Medicare does not cover outpatient prescription drugs. Out-of-pocket expenditures for outpatient prescription drugs were more than $7 billion in 1986.

Older persons consume a disproportionately large percentage of prescription drug products. Although those 65 and older constitute about 12% of the U.S. population, they consume about 30% of the nation's prescription drugs.

Prices of prescription drugs began to skyrocket in 1981 and have far outpaced other items in the Consumer Price Index (CPI) every year since. For the period January 1981 - June 1985, prescription prices rose 56%, compared to 23% for the overall CPI. In 1986, prescription prices were again the highest of all medical care components, increasing at a rate of 8.6% per year, compared to the overall rise in the CPI of 1.9%.

AARP surveyed its members in 1985 and again in 1986 concerning prescription drugs.

In both 1985 and 1986, about 62% of those over 65 said they were taking prescription drugs on a regular basis. Of those taking drugs regularly, about 45% said that they received some assistance paying for those drugs from insurance or other health coverage. This finding was also unchanged from 1985 to 1986.

A significant change occurred, however, in the percentage of people age 65+ paying more for prescription drugs who get no assistance. The number of people who paid more than $41 a month, or over $492 a year, increased by 42 per cent in one year (i.e. 10 percentage points).

4. Home Health Care

Because patients are now discharged earlier from hospitals, home health care is an important component in continuing needed care.

By most measures, home health use has grown greatly. But, the rate of increase in home health expenditures has moderated sharply in the past few years and has not matched previous and expected rates of growth. This fact is puzzling in light of reductions in the average length of hospital stay, the aging of our population, and previous growth rates.

One possible explanation for declining growth rates in home health outlays is that the Health Care Financing Administration (HCFA) is reducing access to this benefit by means of claim denials and the application of vague eligibility criteria. There is some evidence that coverage decisions are arbitrary and capricious and the denial rate certainly varies greatly by geographic area.

HCFA has failed to sponsor careful studies of the impact of prospective payment for hospital care on the need for and use of post-acute care services. Consequently, it is difficult to assess the extent to which the home health services now being provided satisfy demand.

It is clear, however, that Medicare beneficiaries face serious problems in trying to take advantage of this benefit. First, home health care providers are not effectively regulated and quality control and consumer protections are weak or non-existent. The absence of outcome-oriented quality control measures is a significant weakness in the government's oversight of the program, as is the lack of graduated sanctions to apply against providers that fail to meet required minimum standards of performance.

HCFA's policy and practice of restricting home health benefits to homebound persons in need of skilled nursing care on a part-time or intermittent basis following an episode of acute illness reflect the basic orientation of the Medicare program. This emphasis on acute illness leaves a significant gap in insurance coverage and service for the growing number of frail elderly and those with chronic conditions.

5. Medigap's Role in Protecting Beneficiaries Against Catastrophic Costs

The gaps in Medicare's coverage, particularly its cost-sharing requirements, have led to the development of private supplemental insurance plans, so-called "Medigap" policies. About 70% of Medicare beneficiaries are covered by such plans. Since the enactment of the Baucus amendment in 1980, Medigap plans are required to cover: (1) hospital coinsurance; (2) 90% of Part A expenses after exhaustion of the lifetime reserve to a lifetime limit of 365 additional days; and (3) the 20% coinsurance on Medicare Part B services. Such plans are not required to cover either the hospital or physician service deductible, although most offer coverage of the former. Finally, the plans may impose their own deductible of up to $200 per year for Part B coverage.

In spite of the Baucus amendment, there is great variability in the depth and scope of coverage provided by Medigap plans. Most Medigap plans provide little or no coverage of prescription drugs, balance billing by physicians, dental services, and extended nursing home care. Moreover, the Baucus amendment does not apply to employment and labor organization-related group insurance, conversions from group plans to individual policies, and policies in effect before July 1, 1982. Finally, some plans may be very costly relative to the benefit returned to the insured.

It should be noted that supplemental coverage through a Medigap plan is positively correlated with income and education. Yet almost half of elderly people with less than $5000 per year in family income purchase Medigap plans (see chart 3). Even if the coverage selected is modest, the premium payments for such plans must constitute a terrible drain on already meager resources.

Let me at this point clarify the Association's position on the ability of the private insurance industry to protect older Americans from the inadequacies of Medicare's coverage. The Association offers its members a Medicare supplemental insurance plan that fills many of the existing gaps in Medicare coverage.

We believe, however, that filling such gaps through the Medicare program is inherently the most efficient way to insure against acute care catastrophic costs. Accordingly, we welcome any meaningful improvements in the Medicare program that will reduce the need for supplemental insurance plans or make them unnecessary.

6. Medicaid's Role in Protecting Beneficiaries Against Acute Care Catastrophic Costs

It is reassuring to believe that the Medicaid program serves to protect elderly beneficiaries from potentially catastrophic acute care out-of-pocket expenditures. But this is not necessarily the case. The Congressional Budget Office (CBO) reports that in 1986 only 27% of elderly people with family incomes below $5000 were covered by Medicaid (see chart 3). How can this be? We have only to look to the variability in Medicaid's eligibility requirements across states for an answer. There exists no national mandatory income standard for Medicaid eligibility, no mandated coverage of the "medically needy", and no uniformity in eligibility for a Medicaid "buy-in" of Medicare Part B coverage.

7. The Vulnerable Elderly

Who among the elderly are most vulnerable to acute care catastrophic costs? Surely the answer must include those who are not able to afford Medigap coverage, but who also do not qualify for Medicaid coverage. Such individuals tend to be frail, low-income, and uniquely vulnerable to the cumulative financial burden resulting from Medicare coinsurance and deductibles and from the costs of all non-covered services and goods. For nearly 21% of the elderly, Medicare represents the only source of protection (see chart 4).

A second group worthy of particular concern includes the poor/near poor who feel compelled to buy Medigap insurance but who can ill afford it. One can only surmize that such individuals must forego certain day-to-day essentials in order to purchase such protection (see chart 3).

THE ADMINISTRATION PROPOSAL

The Association is encouraged by the demonstrated interest of the Administration and the Congress in finding solutions to the problem of high cost illness for older Americans, although we are disappointed over the almost exclusive preoccupation with costs arising from acute care illness. The Administration proposal based on earlier recommendations of Secretary Bowen addresses only acute care costs, providing beneficiaries with unlimited hospital coverage subject to two deductibles each year and "capping" annual out-of-pocket expenditures for Medicare coinsurance and deductibles at $2000.

The Association recognizes that, through his recommendations to strengthen the Medicare program, Secretary Bowen took an important first step in the development of a viable plan to protect beneficiaries against acute care catastrophic costs. Nevertheless, it must also be recognized that the Secretary's catastrophic proposal -- now the Administration's catastrophic proposal -- is a minimal one. The $2000 cap on coinsurance and deductibles would hardly protect an elderly person of limited or even moderate means from financial catastrophe. Nor is it likely to persuade Medigap holders to drop their supplemental plans and self-insure for the first $2000 in coinsurance and deductibles.

Further, under the Administration plan, no out-of-pocket costs for the following services and products would count toward the annual cap: long-term nursing home care, out-patient prescription drugs, dental services, home health services, physical examinations, balance billing by "non-assigned" physicians, and optical supplies and services. The Administration plan may thus offer some improvement in Medicare's coverage, but it is misleading to suggest that it would provide older Americans with protection against catastrophic health care costs.

Secretary Bowen in developing his catastrophic proposal has given a matter of critical social significance visibility and credibility. He deserves credit for animating discussion and debate on the full range of catastrophic illness issues. Catastrophic proposals developed in the Congress advance this critical exchange of diverse ideas and help us to refine the elements of a workable, comprehensive plan.

AARP'S CATASTROPHIC PACKAGE RECOMMENDATIONS

One of the dilemmas policymakers face in attempting to set a protective "cap" on catastrophic costs is pinpointing the appropriate level for such a cap. Set the cap high, and the benefit can be financed without great difficulty; but as is clear from chart 5, few are protected under such an arrangement. As one pushes the cap down, the protective scope of the cap expands but the cost rises proportionately. Severely restrict the elements of liability which count toward the cap, and the plan becomes more affordable; the danger in this arrangement, of course, is that beneficiaries may wrongly assume that their total out-of-pocket liability in a given year will not exceed the cap level. As they gradually come to realize that a full range of essential medical services and products do not even count toward the "catastrophic" cap, they are apt to feel disappointed, if not duped.

It is important, then, that any plan that lays claim to providing any level of catastrophic protection must identify and appropriately address actual sources of vulnerability. The Association believes that long-term care is the real source of catastrophic costs for older Americans, including middle-income older Americans. We also believe that while acute care costs--for both coinsurance and deductibles as well as non-covered services and goods including prescription drugs-- can threaten the financial security of many older Americans, they are potentially devastating to low-income elderly.

Given these concerns, the Association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more comprehensive than the Administration plan and that, in our opinion, better balances the need for acute care catastrophic protections with the need for long-term care catastrophic protections. It also includes critical protections for low-income Medicare beneficiaries.

We do not delude ourselves in advancing the following set of recommendations that we have solved the catastrophic problem for older Americans. We do believe that in many respects our proposals expand, refine, and improve upon the efforts of others who have also grappled with this complex issue. Our proposals represent an earnest attempt to fulfill the President's pledge to protect Americans against catastrophic health care costs.

The benefit structure of the Association's package can be divided into three pieces:

1. Acute Care
2. Transitional Care
3. Long-term Care

Under the acute care component, we propose the following:

- One hospital deductible per year;
- Elimination of hospital coinsurance;
- Elimination of lifetime limits on hospital care;
- A $1000 cap on Medicare Part B cost-sharing (i.e., deductibles and coinsurance);
- A prescription drug benefit with a $200 annual deductible and a copayment on each filled prescription;
- Improvement in the Medicaid program through the establishment of a uniform mandatory income standard for Medicaid eligibility, and expansion of

coverage through the Medicaid "buy-in" of Medicare Part B services. We view this element of the package as inseparable from the cap which, at $1000, is too high to adequately protect low-income beneficiaries.

Under the transitional care component, we recommend:

- Elimination of SNF coinsurance;
- Elimination of the three-day prior hospitalization requirement for SNF eligibility;
- An expanded home health care benefit;
- A respite benefit (carrying a 50% copayment) to provide assistance to caregivers.

Our long-term care component would include:

- Protection against spousal impoverishment including both income and liquid assets;
- Expansion of home and community-based services; and

- Exploration of the feasibility of capping out-of-pocket costs associated with long-term care.

FINANCING THE BENEFIT PACKAGE

The Association recognizes that, given a burgeoning federal deficit, the kind of improved benefit package we are recommending must be self-financed. Further, results of a recent AARP survey indicate a willingness among a majority of older people to pay increased premiums in return for significantly expanded benefits. Nevertheless, the full burden of the costs of the improved package we are advocating should not fall exclusively upon the elderly. To pay for the improvements we have described above, we propose using an assortment of financing sources, some targeted on improvements in the Medicare program and others targeted on Medicaid remedies. These potential revenue sources include:

Potential Revenue Source	Target	Estimated Yield
o Doubling of the tobacco tax	Medicaid	$2.9 billion (1988)
o Extension of HI coverage to state and local employees	Medicare	$1.3 billion(1988) $5.1 billion over 3 years
o Increase in the Part B Premium not to exceed an additional $10/month	Medicare	Up to $3.7 billion
		Total: $7.9 billion (1988)

The package we have proposed, would probably not represent a replacement for a typical Medigap plan. We believe, however, that responsible private insurers would respond with a corresponding offset (i.e. reduction) in Medigap premiums to match their reduction in risk exposure. Thus, the net additional cost in premiums to the 70% of Medicare beneficiaries carrying supplemental insurance could be minimal. As a complementary measure, our recommended Medicaid improvements would serve to protect those not currently covered by Medigap or Medicaid. The proposal offered by some members of Congress to finance a catastrophic plan by taxing the actuarial or imputed value of that portion of the Medicare benefit that is not paid for by the employee during working years or through the Part B premium represents a radical departure from the financing mechanisms which presently support the Medicare program. While we encourage the exploration of innovative financing approaches to fund catastrophic protections, we are not convinced that a modest benefit package justifies the adoption of such a radical change in existing financing mechanisms. We believe that other financing options should be exhausted before we consider such an approach.

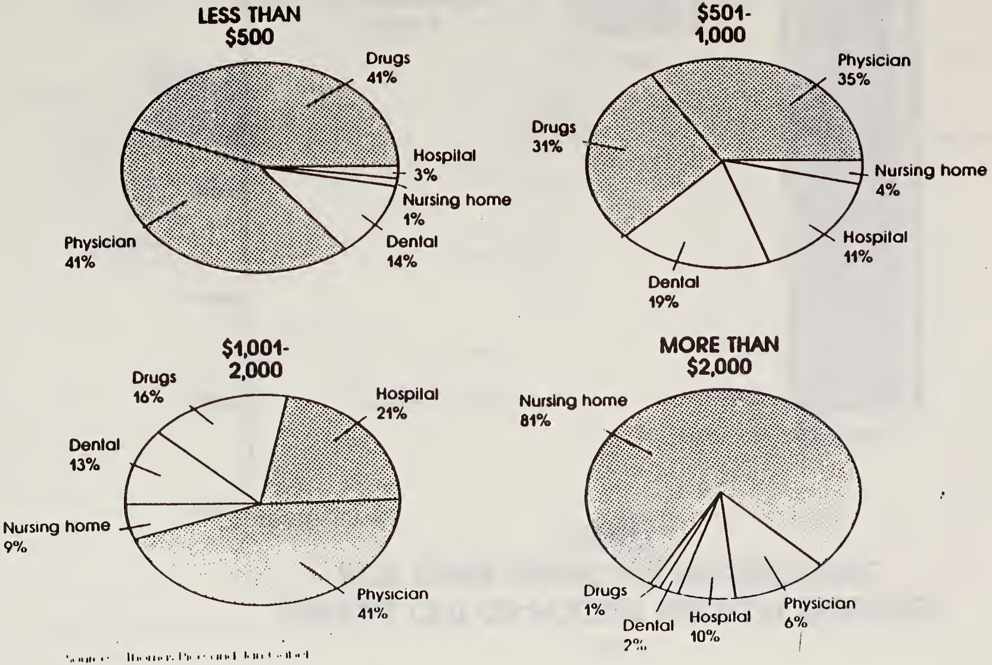
CONCLUSION

I would like to conclude my remarks this morning with two observations. First, we focus our attention here today on the plight of older Americans, many of whom struggle daily under the crushing weight of catastrophic medical costs. Initial action to address their plight is appropriate and, indeed, long overdue. But let us not forget the suffering of some 37 million Americans under the age of 65 who have neither public nor private health insurance and the 15 million who do not have adequate. Surely a nation as richly blessed as ours in material wealth, wisdom, and compassion can summon the resolve to correct this terrible and intolerable social wrong. For our part, we cannot in good conscience support filling the "gaps" in Medicare's coverage, while at the same time ignoring inadequacies in health insurance coverage for working Americans and our nation's children.

Finally, as we convene this morning, we do so with the realization that Congress is poised for action on catastrophic protections for older Americans. Whatever the outcome of this year's initiative on catastrophic illness, let us be scrupulously correct in characterizing to the American public what we have accomplished and, perhaps more importantly, what we have not accomplished in our efforts to come to grips with one of this country's most pressing social needs.

CHART 1

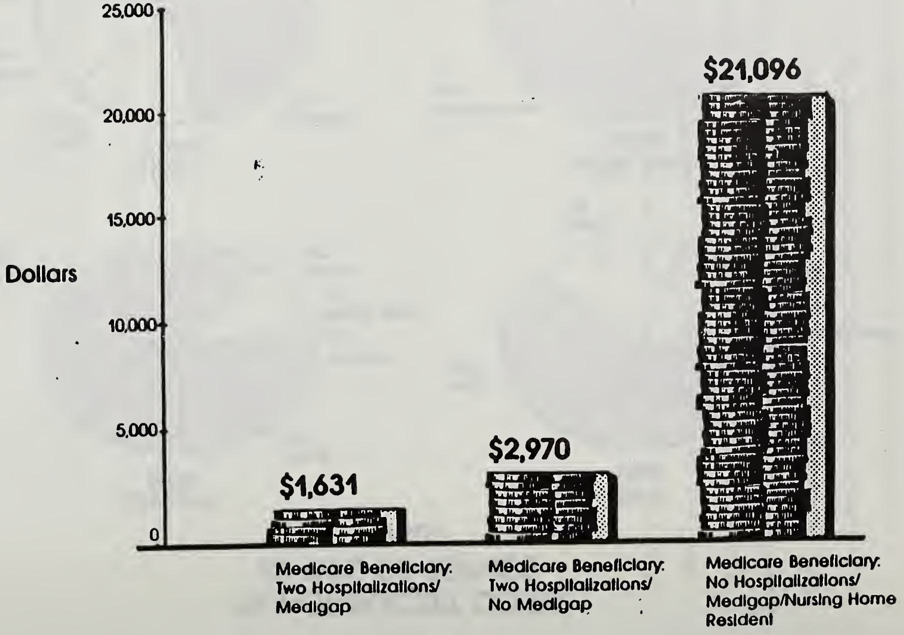
OUT-OF-POCKET COSTS BY TYPE OF SERVICE (1980)



[illegible]

CHART 2

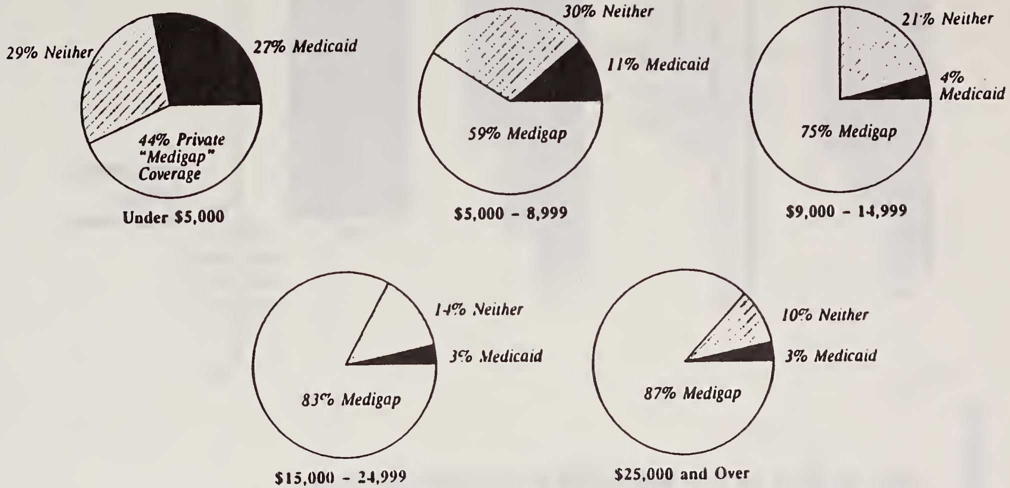
ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



Source Based on Congressional Budget Office preliminary estimates

CHART 3

MEDIGAP COVERAGE FOR THE ELDERLY POPULATION BY FAMILY INCOME, 1986



Source. Congressional Budget Office.

CHART 4

ELDERLY POPULATION WITHOUT PRIVATE HEALTH INSURANCE OR MEDICAID

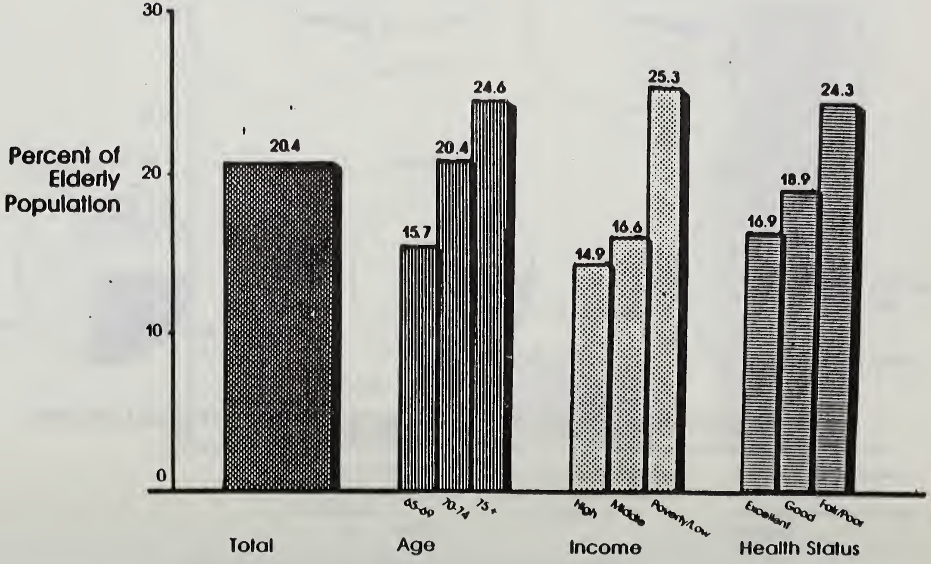
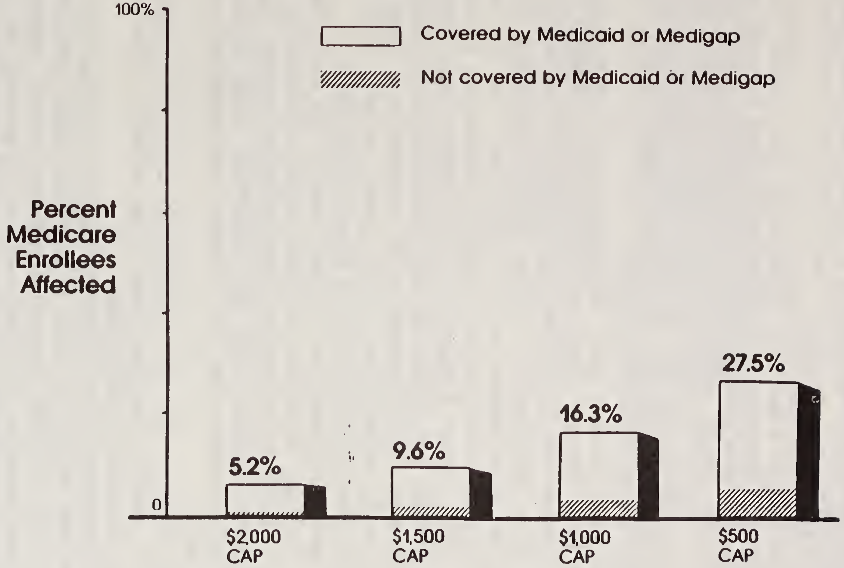


CHART 5

CATASTROPHIC CAPS: WHO BENEFITS?
(1988)



Source: CBO Estimates

Senator ADAMS. Thank you very much, Ms. Crooks.

Dr. Feder?

Dr. FEDER. Thank you.

I am Judith Feder, Co-Director of the Center for Health Policy Studies at Georgetown University Medical School, and I appreciate the opportunity to testify before you today on the research we have done using survey data on the income and acute medical expenses of the elderly. Let me be clear that my remarks deal only with acute medical expenses and do not deal with the separate but important issue of long-term care.

We have heard a great deal today about the medical bills the elderly face despite Medicare's extensive coverage. Whether these out-of-pocket expenses are manageable or catastrophic has a great deal to do with income. Large medical expenses may constitute a financial catastrophe for any individual. But for individuals with low income, even relatively small expenses can be catastrophic.

In 1986, almost a quarter of the elderly spent more than 15 percent of their per capita income out-of-pocket on medical bills. Over one-third of elderly people with incomes less than $10,000 experienced such catastrophe, while among elderly with incomes above $10,000, fewer than 6 percent faced catastrophe.

Catastrophe also has a great deal to do with Medicare's structure. Because Medicare requires equal cost-sharing of all beneficiaries regardless of income, lower-income people face greater proportionate burdens than the better-off. And because cost-sharing rises with service use, the burdens are greatest for those who are most sick.

The elderly who are sufficiently unlucky to have low incomes and to need a hospital stay have a better than even chance of facing financial catastrophe.

Unfortunately, the Administration's proposals for Medicare improvement would do little to alleviate these problems. The Bowen plan, with its $2,000 cap on Medicare-covered expenses, would help the small number of elderly—about 3.5 percent of all elderly—with very large expenses on Medicare cost-sharing. But most people who spend more than 15 percent of income out-of-pocket never reach the $2,000 cap. Eighty-four percent of these people spend less than $2,000 on all their medical expenses, and only about half that spending would count toward the cap.

In other words, most elderly who spend 15 percent of income out-of-pocket reach catastrophe long before they would reach Bowen's proposed limit. Only 6.5 percent of the elderly with catastrophic expenses would spend enough to benefit from the cap.

In sum, a high dollar cap limited to Medicare-covered spending cannot address the fundamental problem of catastrophe which is concentrated among the lower-income elderly.

Legislation to address this problem should expand the services Medicare covers, set caps well below $2,000, and target additional financial protection to the lower-income elderly.

Although our discussion has focused heavily on financial matters, I would be remiss if I failed to comment on the implications of limited insurance for the use of medical care. Lower-income elderly not only experience higher out-of-pocket burdens as a percent of income than the better-off; if they lack Medicaid or private Medigap insurance, they are also likely to get less medical care. People in poor health without supplementary insurance use only about half as much medical care as the people who have supplementary protection.

We must therefore remember that catastrophe is not just financial. High medical costs and limited insurance mean that some people may be going without the care they need.

I commend you and the Committee, Mr. Chairman, for your efforts to alleviate these significant burdens among our Nation's elderly.

Senator ADAMS. Thank you, Dr. Feder.

[The prepared statement of Dr. Feder follows:]

Testimony before the Committee on
Labor and Human Resources
U.S. Senate

"Catastrophic Health Insurance"

Judith Feder, Ph.D.
Co-Director
Center for Health Policy Studies
Georgetown University, School of Medicine

April 8, 1987

Mr. Chairman, members of the committee: I am Judith Feder, Ph.D., Co-Director of the Center for Health Policy Studies of the Georgetown University School of Medicine. I appreciate the opportunity to testify before you today on improving the elderly's protection against catastrophic medical costs. My testimony is based on research I have done with Marilyn Moon, Ph.D., and William Scanlon, Ph.D., using the National Medical Care Use and Expenditure Survey. (That survey was conducted in 1980. Responses have been adjusted to approximate experience in 1986).

Looking only at acute medical care--that is, putting aside the important but separate issue of catastrophe due to long-term care--our research indicates that despite Medicare, a large proportion of the elderly experience catastrophic financial burdens due to illness; that burdens are greatest for the lower income elderly and for the very sick; and that financial burdens appear to limit access to medical care by elderly in poor health who lack private Medigap insurance or Medicaid to supplement their Medicare coverage. Although the Administration's proposal, developed by Secretary Bowen, would fill significant gaps in Medicare's coverage, it would do little to address these fundamental problems of catastrophic medical costs.

Although Medicare finances most of the elderly's medical care, elderly people continue to face sizable medical bills. These bills come from two sources: the premiums and cost-sharing for services Medicare covers (primarily hospital and physician services) and the full cost of services Medicare excludes (like prescription drugs, dental care and eyeglasses).

Whether out-of pocket expenses are manageable or catastrophic has a lot to do with income. Large medical expenses may constitute a financial catastrophe for any individual, but for individuals with low incomes, even relatively small expenses can be catastrophic. In 1986, almost a quarter of the elderly spent more than 15 percent of their per capita incomes out-of-pocket on medical bills. Over one-third of elderly people with incomes less than $10,000 experienced catastrophic burdens (spending over 15 percent of income out-of-pocket). Among elderly with incomes above $10,000, fewer than 6 percent faced such catastrophic expense.

Catastrophe also has a lot to do with Medicare's structure. Because Medicare requires equal cost-sharing of all beneficiaries, regardless of income, lower-income people face greater proportionate burdens than the better-off. And because cost-sharing rises with service use, the burdens are greatest for those who are most sick. Elderly people who are sufficiently unlucky to have low incomes and to require hospital stays have a better-than-even chance of financial catastrophe.

Unfortunately, the Administration's proposals for Medicare improvement would do little to alleviate these problems. The Bowen plan, which sets a $2,000 cap on Medicare-covered expenses, would help the small number of people--about 3.5 percent of the elderly--with very large dollar expenses on Medicare cost sharing.

But most people who spend more than fifteen percent of income out-of-pocket never reach the $2,000 cap. Eighty-four percent of these people spend less than $2,000 on _all_ their medical expenses. Only about half that spending is on services that the cap would cover.

In other words, most elderly who spend fifteen percent of income out-of-pocket reach catastrophe long before they reach Bowen's proposed limit. Only 6.5 percent of the elderly with catastrophic expenses spend enough to benefit from the Bowen cap.

In sum, a high dollar cap on Medicare-covered spending cannot address the fundamental problem of catastrophe, which is concentrated among the lower income elderly. Legislation to address these problems should expand the services Medicare covers, set caps well below $2,000, and target additional financial protection to the lower income elderly.

Although discussions of catastrophe focus on financial burdens, I would be remiss if I failed to comment on the implications of limited insurance for the use of medical care.

Lower income elderly not only experience higher out-of-pocket burdens (as a percent of income) than the better off. If they lack Medicaid or private Medigap insurance, they are also likely to get less medical care. People in poor health without supplementary insurance use only about half as much medical care as people with supplementary protection.

We must therefore remember that catastrophe is not just financial. High medical costs and limited insurance mean that some people may go without the care they need.

I commend you and your committee, Mr. Chairman, for your efforts to alleviate these burdens for our nation's elderly.

Senator ADAMS. Our next witness is Mr. James Moorefield, President of the Health Insurance Association of America.

Mr. Moorefield?

Mr. MOOREFIELD. Thank you, Mr. Chairman.

I am Jim Moorefield, current President of HIAA, but I find my clock is running, and in three and one-half weeks I will be relinquishing my duties as President of HIAA to my successor. I have also just been advised by the Department of Health and Human Services that on June 1, I too will join the ranks of the Medicare elderly. So I have a personal as well as a special interest in this hearing and what may result.

Sir, I was privileged to serve as a member of Secretary Bowen's private-public sector advisory committee on catastrophic illness. After touring the country and hearing from more than 100 witnesses, the advisory committee unanimously concluded that most Americans are adequately protected against catastrophic acute health care expenses by private insurance or by private insurance in combination with public programs.

But they also concluded that there are three most critical catastrophic illness problems that have to be resolved. The first would provide long-term care, which includes home care and intermediate and convalescent nursing home care for the chronically ill. And second, we should find means to provide basic as well as catastrophic health insurance for the 35 million or so Americans who are without any insurance or whose insurance is inadequate to protect against a catastrophic illness—namely, the medically uninsurable, the poor, and the working near-poor. And third, they felt that it was necessary to provide adequate coverage for those 3 to 5 million people, those over 65 who do not qualify for Medicaid and cannot afford the private sector's coverage.

The HIAA compliments the Secretary and President Reagan and the Chairman of this Committee, sir, and you and the other Members of the Committee and others in Congress who are providing a forum to bring the public's attention to the problems of catastrophic illness and give us an opportunity like this where we can debate the issues and, hopefully, advance some viable solutions.

I also appreciate the fiscal restraints in which the Administration and the Congress are working. But I would be less than honest, sir, if I did not express my disappointment with the emphasis that is being placed on the need to first restructure the Medicare system, a system that is working and a system that, when it is coupled with private insurance, or with Medicaid, is working extremely well.

I respectfully suggest, sir, that the present focus on Medicare restructuring is misdirected, and that the focus should be on the long-term care needs of the public and on providing adequate coverage for the uninsurables, the poor, and the near-poor.

I am proud of the industry's record in providing coverage. Most Medigap policies being written today exceed the Baucus standards. Most provide benefits equal to or even in excess of those that Secretary Bowen and others are proposing.

For example, a very recent survey of the top 12 commercial Medigap insurers, which represents about 66 percent of the commercial Medigap business, shows that 86 percent of those policies now provide unlimited—unlimited—hospital days, paying 100 percent of all Medicare-allowable hospital expenses, and that 93 percent of those policies provide unlimited coverage for Medicare-allowable Part B expenses.

The industry is doing a good job in filling the Medicare gaps. But if this Committee or others feel that it is necessary to somehow assure more generous benefits than are now provided by Medicare, we suggest, sir, that you expand the Baucus minimums to include and assure a catastrophic feature and that you enact legislation that would allow us, the private sector, to provide a freestanding catastrophic affordable policy—one that is equal to Bowen or exceeds it.

The Medicare-Medicaid private health system is working well for 80 percent of those age 65 or over. Of the remaining 20 percent, as the chart illustrates up there, about half can afford, but choose for whatever reason not to purchase supplementary insurance. You should concentrate, sir, on the ways to provide adequate coverage for the remaining 10 percent of those who do not qualify for Medicaid and cannot afford a private policy.

The entire Medigap-Medicare system does not have to be restructured to meet the needs of that 10 percent of America's population that are age 65 or over. Our statement, which you have in hand, outlines the viable solutions to the Medicare problem, as well as what can be done to fill the more critical gaps in coverage, namely, long-term care coverage and coverage with the poor, the working near-poor, and for the medically-uninsurable.

Sir, our association stands ready, as does my successor if I am not around, to give you all the assistance that you may need.

Thank you.

[The prepared statement of Mr. Moorefield, with an enclosure, follows:]

Statement

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

PROPOSALS TO PROVIDE CATASTROPHIC COVERAGE UNDER MEDICARE

Presented by

James L. Moorefield
President

Before the

Committee on Labor and Human Resources
United States Senate

April 8, 1987

Washington, D.C.

I am James L. Moorefield, President of the Health Insurance Association of America. The HIAA is a trade association with a membership of about 335 insurance companies. Our members write over 85 percent of the private health insurance available from insurance companies in this country.

The nature of our business has given the HIAA considerable experience in the field of health benefits over the last thirty years. We urge you to use this practical knowledge as you study the health care needs of people in this country.

To judge from news reports, the question of the hour is: Do Americans run the risk of financial ruin when faced with a catastrophic illness? In his report to the President last November, HHS Secretary Bowen said that the present health care system provides substantial benefits to most people. He noted that virtually all the elderly and nine out of ten people in the general population have health insurance. But he warned of gaps in catastrophic coverage that need to be filled, especially for older Americans and the working poor.

In the case of the elderly, some of these gaps have already been closed by a partnership between government and private insurers that protects older people from catastrophic hospital and medical bills. Medicare pays a large portion of the elderly's expenses for acute illness and private insurance policies known as "medigap" pick up the deductibles and coinsurance -- those gaps in coverage that Medicare assigns to the elderly to pay themselves. Today, seven out of ten older people have some form of private insurance or medigap to supplement their Medicare benefits thereby avoiding catastrophic hospital and medical bills.

A medigap policy allows older Americans to spend up to 150 days -- that's nearly five months -- in a hospital without paying any Medicare coinsurance. And, if an elderly patient exhausts his 150 day Medicare hospital benefits, but needs to remain in the hospital, his private medigap policy will cover another 365 days, paying at least 90 percent of all Medicare allowable hospital expenses.

In addition to covering hospital expenses, medigap policies help older people with some of their other medical expenses, particularly doctor's bills. Medicare pays 80 percent of these medical bills after determining the "reasonable and customary" charge for the services performed. Private medigap policies pick up the remaining 20 percent of expenses allowed by Medicare up to at least $5,000 a year.

Medigap policies are regulated by the states and must meed the standards I just described. These minimum standards were set by the Baucus Amendment to the 1980 Social Security Disability Act, an amendment designed to protect the elderly from overpriced or substandard medigap insurance policies. The standards set up by the Baucus amendment have been adopted in 46 of the 50 states, Puerto Rico and the District of Columbia.

In addition to enforcing minimum coverage standards for medigap policies, state laws also require insurers to pay benefits for pre-existing health conditions after the medigap policy has been in force for six months. Benefit payments must increase to keep up with rising health care costs along with changes in Medicare co-payments and deductibles. Older people are allowed to return the policy within 10 days for a full refund. Companies that sell Medigap insurance are also bound by fair trade practices such as simplified policy language and truth-in-advertising designed to protect the consumer.

I should also point out that current state law requires insurers to provide medigap consumers with simplified explanatory materials which describe what benefits Medicare and medigap policies do and do not cover. This Guide to Health Insurance for People with Medicare was developed by the National Association of Insurance Commissioners in coordination with the HIAA and the Health Care Financing Administration.

The conditions I have just mentioned are purely minimum standards that most medigap policies surpass. Many provide "first dollar" coverage by picking up the Medicare Part A hospital deductible (currently $520), as well as the Part B annual medical deductible of $75. A recent HIAA survey of 12 top commercial medigap carriers (representing about 66% of the total individual medigap business written by commercial insurers) shows that 86% of their policies covered unlimited hospital days, paying 100 percent of all Medicare allowable hospital expenses. The same survey showed that 93% of those companies' policies had unlimited coverage for Medicare allowable Part B expenses. Some medigap policies also cover expenses that Medicare will not pay for at all, such as dental and vision care, routine check-ups, hearing aids and out-patient drugs.

Last year, the GAO was asked to investigate the effectiveness of the Baucus Amendment in assuring the elderly that medigap policies meet their needs. The congressional watchdog agency reported its findings to the House Ways and Means Subcommittee on Health last October. In its review of 142 policies sold by 92 commercial insurers and 13 Blue Cross/Blue Shield plans, the GAO made no recommendations for further controls since, it said, the elderly were receiving adequate protection.

The GAO report also found that medigap policies sold by commercial companies with more than $50 million in premiums generally met the Baucus loss ratio requirements. That means that at least 60 cents of every premium dollar was returned as benefits or added to reserves. The loss ratios for the most commonly purchased policies, however, generally exceeded the recommendations found in the Baucus Amendment. For example, coverage sold by The Prudential Insurance Company for AARP members must by contract pay 80 cents of every dollar in benefits. Currently, about 10% of all Medicare beneficiaries have such coverage through the AARP. It is also important to point out that HIAA surveys show that nearly 40 percent of all medigap is purchased on a group basis. The Baucus Amendment requires all medigap sold on a group basis to pay at least 75 cents of every premium dollar in benefits.

The GAO report concludes that the protection these policies give the elderly could be considered a form of catastrophic health insurance. But the report also noted that few Medigap beneficiaries need this benefit since HCFA data shows that only about 2,000 Medicare beneficiaries, or .007 percent of people 65 and older, spent more than 150 days in the hospital in 1984.

It would seem then that older people who have bought medigap policies do not need to worry about catastrophic hospital expenses. They are, however, exposed to more serious financial consequences when faced with doctor bills since Medicare will only pay 80 percent of what it considers "reasonable and customary" medical charges. Even though medigap insurance picks up the remaining 20 percent of the Medicare allowance, older people are still responsible for paying the difference between what their insurance reimburses and what their physician charges.

Older people would be helped with this problem if the Health Care Financing Administration helped them identify those physicians and other providers who accept Medicare's fees as full payment for their services. HCFA could publish directories with the names and addresses of participating physicians and even provide toll-free hotlines. It could also develop incentives for electronic billing of physician claims as well as for streamlining the coordination of billing for Medicare and Medigap benefits.

We would also encourage Medicare to be more aggressive in its pursuit of cost containment. This means more stringent utilization review, pre-admission certification and mandatory second surgical opinion programs. These are all techniques used routinely in privately managed health care plans.

In spite of these problems, Medicare and private health insurance are protecting most of the nation's elderly from catastrophic acute care costs. In January 1987, the HIAA commissioned Market Facts, one of the largest marketing firms in the country, to assess consumer experience with medigap policies. Over 1,500 people 65 and older who have medigap policies were surveyed from a demographically balanced national sample. The survey found that 8 in 10 say they were not pressured into purchasing a medigap policy and an equal number say that their policy was fairly priced. Among those who have already filed a claim with their medigap insurer, 8 in 10 say that the claim was promptly paid and that the insurer paid as much of their medical costs as they expected. The survey also revealed that 9 in 10 of the people who filed a claim were satisfied with their policies. I have brought copies of a detailed report on this survey with me today which I will distribute to anyone interested in it.

Our research also indicates that Medicare and private health insurance are protecting about 70 percent of the nation's elderly from catastrophic acute care costs. Medicare and Medicaid cover another 10 percent, leaving 20 percent of those 65 and older vulnerable to the gaps in Medicare's hospital and medical benefits. About half of these people can afford private supplemental insurance, but have chosen not to purchase it. The remaining 10 percent of the elderly have no medigap insurance, but are not eligible for Medicaid. These are the elderly who need help most.

INSURANCE INDUSTRY ALTERNATIVES TO MEDICARE CATASTROPHIC LEGISLATION: AMEND BAUCUS

Including Catastrophic Features in Minimum Standards

The commercial health insurance industry believes that restructuring Medicare to cover catastrophic acute health expenses as proposed will provide limited benefits to few people, that most beneficiaries already have adequate private protection and that current proposals do not address true catastrophic expenses, such as long term care.

We feel that the private sector should be allowed to continue offering this protection. One way to assure that all Medigap meets Congress' new test for catastrophic acute medical expenses is to amend the Baucus law to make unlimited hospital and Part B coverage a minimum standard.

Amending Baucus So That Insurers Can Offer a Catastrophic "Stand Alone" Plan

Congress should bear in mind before criticizing the industry regarding what it thinks is a failure to offer catastrophic coverage similar to the Bowen plan, that the 1980 Baucus standards are what Congress, the Administration, insurers, state insurance regulators, and consumers decided were necessary coverages when that legislation was being debated. Secretary Bowen simply has refocused the debate.

Insurers currently cannot write a stand-alone Bowen-type "catastrophic" policy and market it as a Medicare supplemental plan. This is because it would not match the Baucus minimum standards. Under current law some states would allow us to write such a limited benefit plan, so long as it is not called "Medigap." However, this could confuse consumers and thus limit such a plans' market appeal. If Baucus was amended so that insurers could underwrite a Bowen-type product and market it as a Medigap policy, this problem could be averted. Insurers feel that they can underwrite such a policy and sell it at a price comparable to Bowen's.

MEDICARE CATASTROPHIC LEGISLATION: ACCOMMODATING EXISTING PRIVATE COVERAGE

Waiver for Private Coverage

If a Medicare catastrophic restructuring plan is approved by Congress, such a bill might include a waiver provision so that if beneficiaries wish to be covered by a private Medigap plan rather than under new Medicare benefits, they may do so.

Many Medigap policies provide first dollar coverage and cover benefits that Medicare does not, such as physician balanced billing, vision and dental care, and prescription drugs. Allowing beneficiaries to choose this coverage to supplement current Medicare benefits, rather than rewriting Baucus, state laws, and private plans so that insurers can sell coverage to meet any gaps left over after a Medicare catastrophic plan is passed, would save months or years of confusion both among consumers and in the insurance marketplace. Also such a waiver would do nothing to prevent beneficiaries from choosing the government plan.

Transition Rules

Finally, if a Medicare catastrophic plan is approved by Congress, adequate transition rules should be included allowing time for states to change existing laws regulating the Medigap business. At least an 18 month to 2 year period would be needed because some state legislatures meet only every other year.

If a Medicare catastrophic plan passes, it is likely that existing Medigap coverage would be considered duplicative. It is currently a violation of the Federal Baucus law to knowingly sell duplicative coverage unless the benefit payments are also duplicative. We are concerned that payments for claims would be made by both Medicare and private insurance. The negative cost containment factor upon both programs is real.

In addition, many private supplemental policies are "guaranteed renewable." This means that if new laws are passed affecting existing private coverage, insurers will be restricted from making changes in benefits that would dove-tail or supplement new Medicare benefits. The result would be additional and substantial consumer confusion over the relationship between private and governmental coverages.

Further, Baucus includes many consumer protections. For these reasons, the Baucus law will have to be amended and a transition period will have to be provided if the industry is to continue to cover any gaps in coverage which may remain after a Medicare restructuring law is passed.

PRE-FUNDING RETIREE HEALTH BENEFITS

Another way to ensure that more Medicare beneficiaries have protection for gaps in coverage is to encourage more employers to provide health insurance benefits to their retired workers. The U.S. Department of Labor reports that currently only 57 percent of employees in large and medium-sized companies will receive employer-provided health benefits that supplement Medicare when they retire. Although this percentage is expected to grow, coinciding with the growing number of the elderly, the present federal tax policy is a major reason why many more employers are choosing not to do more for their retirees.

Specifically, the Deficit Reduction Act of 1984 has limited the tax advantage to pre-funding retiree health benefits. The HIAA urges Congress to consider the wisdom of a federal tax policy that discourages people from making financial arrangements today which would help pay for their health care tomorrow.

LONG TERM CARE: THE REAL CATASTROPHE

Pre-funding for retiree health care would also help working people prepare for the biggest catastrophic health care cost of old age -- long-term care, the catastrophic expense that 90 percent of the elderly are unprotected from today.

A recent study, financed by the National Center for Health Service Research, determined that older people who had more than $2,000 worth of out-of-pocket expenses in a given year, spent 81 percent of this additional expense on nursing home care. At the same time, their annual out-of-pocket expenses for hospital and physicians fees were respectively 10 and 6 percent.

Most people do not realize the enormity of the risk they run when facing long-term care. In 1985, the insurance industry conducted a survey of 1,000

Americans between the ages of 50 and 64. Through it we learned that although more than half of them worry about a chronic illness or disability in their old age, less than one-fourth of them know that Medicare will be of little use to them should they ever need long-term care. Even more telling is the finding of a recent survey of the elderly by the AARP: about 80% believe Medicare covers long-term care.

Misconceptions about government assistance in paying for long-term care are echoed in popular beliefs about the role that private insurance plays in providing this kind of protection. In spite of industry educational campaigns, many older people still think that they already have long-term care coverage because they own a medigap policy. But medigap insurance is not long-term care insurance. Medicare's coverage of long-term care is limited and since medigap policies are designed to supplement Medicare, medigap long-term care benefits are also limited.

In an effort to eliminate these misconceptions, I personally offered the HIAA's assistance to HHS Secretary Bowen in embarking on two educational campaigns regarding the benefits and limitations of the Medicare program and the need for financial protection against expenses associated with long-term care. Our discussions have focused on targeting middle-aged sons and daughters of the elderly, as well as the elderly themselves. Although this effort is still in an exploratory stage, we feel the prospects for the campaign are promising.

The HIAA also has recently expanded existing educational programs regarding the need for long term care and defining what is and is not covered by Medicare and medigap. Following are some of our activities:

- Educational booklets for consumers, policymakers, and legislators.
- Op-ed and other advertising focusing on long-term care, Medicare and medigap (a medigap "Know Your Rights" ad has run in 50 Plus magazine and will soon run in newspapers in selected areas of the country.
- Consumer and agent-oriented slide shows.
- A consumer 800 number for information on the availability of long term care insurance in every state.
- Media seminars on long-term care.
- Long-term care kits for HIAA member companies designed to encourage development of new products.

Americans may not yet have accepted the idea that they need long-term care protection, but private long-term care insurance is available. In 1986 we surveyed our member companies and found that as of June 1986, 12 of them were offering individual long-term care policies of the indemnity-type. These are policies which offer a fixed amount of money per day. Since completing our survey we learned that four more member companies have entered the market. Today, an average of six HIAA companies are selling policies in each of the 50 states.

What is covered by the typical private long-term care policy? In our survey, we defined this type of policy as one which covers nursing home stays and/or home health care for not less than 12 consecutive months. The maximum benefit period for a typical policy, however, is 3 years, although a substantial number offer 5 years of coverage. This coverage appears to be adequate since one half of all nursing home residents stay only 90 days and 93 percent of all residents are discharged within 5 years.

Services covered in these policies include skilled, intermediate, custodial and home health care. Of the 12 policies analyzed in our survey, all offer skilled nursing care, 10 also provide intermediate nursing and custodial care, 8 include home health care, and 2 pay a cash benefit for purchasing necessary care at home.

We do not know how many long-term care policies have been sold because many companies have just entered the market. The companies that do have tallies, however, tell us that there were about 130,000 policyholders as of January 1986. Their average policyholder is 75 years old.

Another 15 HIAA companies are developing new long-term care products. Many of these are "group" policies which means they can be sold at a lower premium with little or no individual underwriting.

We believe that private long-term care insurance can play an important role in protecting many elderly from catastrophic long-term care costs. However, consumer education regarding the shortcomings of existing coverage is critical to the success of any long-term care financing scheme.

CATASTROPHIC PROTECTION FOR THE UNDER 65 POPULATION

But what about the people who are under 65 years of age? For the working population, studies of group health insurance plans offered by employers show:

o 172 million individuals have major medical coverage providing hospital and medical benefits.

o Nearly 80% of working people today having maximum benefits of $1,000,000 or more (compared to 46 percent in 1980).

o 91% of all insured working people have limited out-of-pocket expenses of $2,000 or less (compared to 75 percent in 1980).

o Over 99% of all insured employees are covered for inpatient expenses associated with mental and nervous disorders.

o Over half of all insured employees have coverage for home health care and almost two thirds for second surgical opinions.

For the working poor, who earn less than $10,000 a year, but have no health insurance benefits, we suggest that Congress enact incentives to encourage small companies to cover their employees. Dr. Bowen proposed offering the self-employed full deductions on their own health insurance plans as long as they cover their employees as well.

We would also urge that state mandatory benefit laws be removed so that insurers can offer less expensive catastrophic-only health plans to small employers. States could also be given greater flexibility with Medicaid programs in order to cover the medically needy independent of other welfare programs and to cover low-income working parents, as well. It might also be possible to offer a subsidized Medicaid "buy-in" for uninsured low-income people who are not eligible for Medicaid.

We cannot fail to mention those who have no health insurance because they have chronic health problems such as diabetes, heart disease or AIDS that have made them ineligible for private individual insurance. Many of these individuals are working or can otherwise afford to buy coverage. The HIAA supports proposals to make health insurance available for those who find themselves in this situation. Last year, we supported legislation introduced during the 99th Congress by you, Chairman Kennedy, which would encourage states to establish risk pools for people considered uninsurable. We expect similar legislation to be introduced this year and we will continue to support these efforts.

Eleven states currently have some form of health insurance pool for uninsurables: Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, Illinois, Tennessee, and Wisconsin. In 1975, the HIAA supported the creation of the first state risk pool in Connecticut. Because of this pool, there are now no uninsurables in Connecticut. Under the Connecticut law, the losses of the pool were to be shared among all the competitors in the health insurance market place -- the commercial insurers, Blue Cross/Blue Shield, HMO's, and self-insured employers -- on a pro-rata basis. Thus, the high-risk individuals received coverage but the competitive market place was not upset.

Subsequent court interpretation of the 1974 Employees Retirement Income Security Act (ERISA), however, which precludes the states from regulating employee benefit plans, means self-insured employers need not share in any pool losses. As more and more large employers self-insure, the burden of pool losses falls harder and harder on an ever decreasing base, principally small employers and individual purchasers of health insurance policies, who are already paying higher costs for their health protection. Federal legislation is required to solve this problem and to guarantee the establishment of a program in every state.

Most important, the state high risk pool would ensure the availability of health insurance for all Americans, regardless of health condition, with minimum federal regulation and at no cost to the federal treasury.

Finding ways to protect Americans from catastrophic health bills is complex because the elderly, workers, the poor and the uninsurables have different needs. Solving their problems will take time and ingenuity on the part of the legislators and insurers. But I think it is important to stress that our state and federal resources are limited. And what funds we have should be used to help the most vulnerable among us. Public money should not be spent to replace coverage adequately provided to the majority by the private sector.

Thank you, Chairman Kennedy, and members of the Committee for this opportunity to testify. The Health Insurance Association of America is willing to offer its assistance to this committee as you deliberate this pressing national issue.

**HEALTH
INSURANCE
ASSOCIATION
OF AMERICA**
1025 Connecticut Avenue, N.W., Washington, D.C. 20036-3998, (202) 223-7780

April 30, 1987

Mr. Thomas M. Rollins
Staff Director and Chief Counsel
Committee on Labor and Human Resources
United States Senate
Washington, D. C. 20510

Dear Mr. Rollins:

On April 8, HIAA President James L. Moorefield testified before your Committee on the subject of catastrophic health insurance for Medicare beneficiaries. During questioning, Senator Adams asked the HIAA to supply the Committee with information on retention rates for ("Medigap") commercial Medicare Supplement insurance products. Our actuaries have researched that information for three top commercial carriers.

One large Medigap writer reported 85% persistency or retention of new and renewal business. This means that 70% of those who purchased this insurance retained their coverage after the policy's renewal date. Another large Medigap writer reported 70% persistency after 15 months, which they reported to be better than their other books of business. A third large Medigap writer reported that persistancy for their Medigap business was greater than 80%, even with a rate increase. Obviously, this date completely contradicts Senator Adams' statement that rentention rates for private coverage is low, specifically "between 10 and 40 percent".

We hope that this information is helpful to the Committee as it debates this important issue. The commercial health insurance industry is proud of its record of providing catastrophic protection against acute medical expenses for our nation's elderly. Please feel free to contact our staff at any time should you need further information on health insurance related issues.

Sincerely,

Linda Jenckes

Linda Jenckes
Vice President &
Federal Affairs

Enclosure

(NOTE: In the interest of economy, the enclosure accompanying this letter was retained in the files of the Committee.)

Senator **Adams**. Mr. Moorefield, would HIAA support the Bowen plan?

Mr. **Moorefield**. No, sir. We believe, as others have testified today, sir, that it does not add any new benefit. It is, by being touted as a catastrophic policy, misleading. The same problems that the Medicare population is facing today, with bills not being paid, are going to continue. Only 2,000 people, according to HHS's own figures, are in the hospital for more than 150 days. We have heard of the problems just expressed by my associates here at the table that the $2,000 would cause those who are near-poor or poor to spend down into Medicaid. There are already 500,000 people a year, as you heard Secretary Bowen say, that have to spend down in order to get nursing home care. We feel that those are the problems that should be addressed, sir. The Medigap business is providing coverage for those who can afford it. Let us look at those who cannot.

Senator **Adams**. Isn't it true, Mr. Moorefield, that the retention rates for private coverage are between 10 and 40 percent, and often higher—in other words, that people are dropping out of it—whereas your administrative costs for Medicare are about 2 percent? Is there a sound public policy argument for providing a Medicare coverage for catastrophic illness?

Mr. **Moorefield**. I think you have to look at what you are buying, sir. Of course the Government, through Medicare, does not have the marketing costs, does not have to pay the taxes, and so forth, that the private sector does. And there is that difference. But I think you have to look at the benefits that are provided in relation to the premiums that are charged for it.

Senator **Adams**. My question really is aren't people dropping out of it.

Mr. **Moorefield**. Oh, excuse me. Retention rates—is that what you said, sir?

Senator **Adams**. Yes, the retention rate.

Mr. **Moorefield**. Retention rate. I do not have those figures. I would be glad to explore it with our larger companies.

Senator **Adams**. Would you supply them to the Committee, please?

Mr. **Moorefield**. Yes, sir.

Senator **Adams**. Before I go to the last witness, Dr. Feder, would you support the Bowen plan?

Dr. **Feder**. Senator, I would have to distinguish the cap from the way it is financed. Although I think we should do much better than the Bowen proposal, I do believe that we should not ignore a chance to make a small improvement in the Medicare benefit if that is the only thing that can be done.

However, the Bowen plan is financed from premiums that are charged equally across-the-board for all elderly. It therefore would worsen the financial problem for the lower-income elderly while they are unable to spend enough to derive very much of its benefits.

So given the financing mechanism, I could not approve the plan.

Senator **Adams**. Ms. Crooks?

Ms. **Crooks**. Well, at the present time, I do not believe we could approve it, but we are willing to look at packages that you people might propose, but at the present time, we think that this just does not go far enough in the right direction, because we are very interested in long-term care. But we are willing to look at other alternatives.

Senator ADAMS. Thank you.

Dr. Brickner?

Dr. BRICKNER. Thank you, Mr. Chairman.

I am a physician from New York City, and I work at Saint Vincent's Hospital. I am here representing only myself, with a background of some 14 years of work in the field of long-term home health care for the frail aged.

The legislation that we are discussing today, in my view, is significant and important in that it insures against the catastrophic expenses of those under treatment in acute care hospital beds for prolonged periods.

The legislation is also significant because it uses the Medicare program as the mechanism for coverage.

As we have all recognized here today, Medicare is an empirically proven, trusted and reliable insurance program in the views of most older persons in this country. However, in recent years, the failure of Medicare regulations to allow payment for the cost of chronic disability has come under scrutiny. The present legislation is perhaps the first to focus on chronicity of disease as a matter of concern. This is a most important precedent. And I want to emphasize that, even though it is in the disguise of coverage for acute care, for the first time a proposal has come forth making a serious case for dealing with chronic disabilities. After all, a patient who must remain in an acute care bed for a year really, in fact, is under treatment for a disease which has become chronic.

Unfortunately, this legislation does not take the next necessary major step. Its benefits will accrue only to those persons, small in number, who must stay in hospitals for lengthy periods. The bill will not provide help for the majority of older disabled individuals who face the much more common financial catastrophe of long-term chronic disease while living at home. The bill fails to respond to the demographic imperative of the aging in this country.

A significant proportion of the growing number of older persons in the next 20 to 50 years will be disabled and will need help. Without further Medicare amendment, they will not get the help they need.

The frail and disabled aged have few acceptable options for care today. Pressure to leave a hospital bed is inevitable once the acute phase of illness or injury has passed. Where next?

Nursing homes are crowded and expensive, and placement in such institutions will be increasingly limited to the most disabled and helpless of the aged, those that demonstrably must receive 24-hour-a-day care. The vast proportion of frail older persons, then, will need and will usually wish to receive services at home.

At Saint Vincent's Hospital in New York where I work, we have been caring for homebound aged persons in the community with hospital-based, doctor-nurse-social worker teams since 1973. We have made more than 18,000 home visits in this 14-year period and have had more than 1,500 individuals under care. Two-thirds are women; two-thirds live alone. The common, strongly expressed desire of our patients, whose average age is 83 years, is summed up by the remark of one woman as our team arrived for its first home visit: Thank God you're here. If only you keep me out of a nursing home.

If we fail to act, we may well repeat the catastrophe of the deinstitutionalization movement of the chronic mentally ill. In the early 1960s, the civil rights activists of that era combined with leadership in State governments to discharge from State mental hospitals—the asylums—many patients with long-term emotional illness. In theory, community-based programs such as clinics and halfway houses were to serve instead, when combined with the benefits of new drugs such as chlorpromazine. However, as a walk through any major city will show, many mentally ill persons are struggling without shelter—without asylum—on the streets, in the parks, on riverbanks, under viaducts, in train and bus stations.

The major distinction between the chronic mentally ill and many of the frail elderly is that the latter will suffer out of sight, in their own rooms, apartments or homes, without adequate help.

It is my personal view that this present bill should be passed. Then we should move promptly on to the next task, which is amendment of Medicare to insure against the catastrophic expense of chronic disease and to wean it from its present focus on acute illness. Arbitrary regulations now bar persons entitled to Medicare from long-term services through devices such as the skilled nursing and the intermittent care requirements. It is as though those with prolonged illness cannot need skilled care, and that the cost of care should be covered only if the disease requires attention intermittently.

This makes no sense. We should recognize that the catastrophic health care problems of the elderly, such as those caused by the dementias, stroke, chronic heart and lung disease, arthritis, fractures of the leg and hip, demand skilled care over the long term.

Thank you.

[The prepared statement of Dr. Brickner follows:]

TESTIMONY ON
CATASTROPHIC ILLNESS EXPENSES LEGISLATION BY

PHILIP W. BRICKNER, M.D.
DIRECTOR, DEPARTMENT OF COMMUNITY MEDICINE
SAINT VINCENT'S HOSPITAL AND MEDICAL CENTER
OF NEW YORK

APRIL 8, 1987 DIRKSEN SENATE OFFICE BUILDING

Older persons in the United States particularly need protection against the costs of catastrophic illness. This legislation is significant and important in its design to insure against the catastrophic expenses of those under treatment in acute care hospital beds for prolonged periods. The legislation is also significant because it uses the Medicare program as the mechanism through which coverage will be provided. Medicare is an empirically proven, trusted and reliable insurance program, in the views of most older persons in our country. However, in recent years the failure of Medicare regulations to allow payment for the costs of chronic disability has come under scrutiny, and the present legislation is perhaps the first to focus on chronicity of disease as a matter of concern.

Unfortunately, this legislation does not take the next necessary major step. Its benefits will accrue only to those persons, small in number, who must stay in hospitals for lengthy periods of time. The bill will not provide help for the majority of older disabled individuals who face the much more common financial catastrophe of long term chronic disease. The bill fails to respond to the demographic imperative of the aging in this country, that fact that over the next several decades the numbers of those over age 65 years will double from the present figure, and those over age 85 will quadruple. A significant proportion of these older persons will be disabled, and will need help. Without further Medicare amendment, they will not get the help they need.

The frail and disabled aged have few acceptable options for care today. Pressure to leave a hospital bed is inevitable, once the acute phase of illness or injury has passed. Where next? Nursing homes are crowded and expensive; and placement in such institutions will be increasingly limited to the most disabled and helpless of the aged, those that demonstrably must receive twenty-four hour a day care. The vast proportion of frail older persons, then, will need, and will usually wish to receive, services at home. At Saint Vincent's Hospital in New York City we have been caring for homebound aged persons in the community with hospital-based doctor-nurse-social worker teams since 1973. We have made more than 18,000 home visits in this fourteen-year period, and have cared for about 1500 individuals. Two-thirds are women. Two-thirds live alone. The common, strongly-expressed desire of our patients, whose average age is 83 years, is summed up by the remark of one women as our team arrived for its first home visit: "Thank God you're here. If only you'll keep me out of a nursing home."

If we fail to act, we may well repeat the catastrophe of the deinstitutionalization movement of the chronic mentally ill. In the early 1960's the civil rights activists of that era combined with leadership in state governments to discharge from state mental hospitals, the asylums, many patients with long-term emotional illness. In theory, new community-based programs such as clinics and half-way houses were to serve instead, when combined with the benefits new drugs such as chlorpromazine. However, as a walk through any major city will show, many mentally ill persons are struggling without shelter, without asylum, on the streets, in the parks, on riverbanks, under viaducts, in train and bus stations. The major distinction between the chronic mentally ill and many of the frail elderly is that the latter will suffer out of sight, in their own rooms, apartments or homes, without adequate help.

I urge that the present bill be passed. Then, we should move on to the next task: amendment of Medicare to insure against the catastrophic costs of chronic disease, to wean it from its sole focus on acute illness. Arbitrary regulations now bar persons entitled to Medicare from long term services through devices such as the skilled nursing and the intermittent care requirements. It is as though those with prolonged illness cannot need skilled care, and that the costs of care should be covered only if the disease requires attention intermittently. This makes no sense. We should recognize that the catastrophic health care problems of the elderly, such as those caused by the dementias, stroke, chronic heart and lung disease, arthritis, fractures of the leg and hip, demand skilled care over the long term.

Prompt consideration should be given to funding for a spectrum of non-institutional services for the frail aged. Medicare amendment is a prioity. In addition, new forms of insurance, innovative uses of personal assets such as home equity loans, and various types of personal housing should be considered. The "Home and Community Based Services Act of 1987", sponsored by Senator Orrin Hatch, is a significant opportunity. It allows grant funds to be used across the country for innovative home health care programs. Passage of Senator Hatch's bill is one of many actions that will be needed to deal in a prompt, temperate, logical, orderly and humane manner with the catastrophe of chronic disability among the growing numbers of frail and disabled older persons in this country.

(NOTE: Due to printing limitations, and in the interest of economy, the 1986 Annual Report of St. Vincent's Hospital submitted by Dr. Brickner was retained in the files of the Committee.)

Senator Adams. Thank you, Doctor, very much.

The Committee wants to thank each and every member of the panel. You answered my question in the course of your testimony, Dr. Brickner, and I appreciate that.

The Committee will now stand at recess. We want to express on behalf of everyone on the Committee our appreciation for your being here, for your testimony, and as I indicated earlier, your full statements will appear in the record.

[Additional statements and material submitted for the record follow:]

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Deputy Director, Business Administration

February 2, 1987

The Honorable Ted Kennedy
Chairman
Senate Labor and Human Resources Committee
113 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

The American Psychiatric Association (a medical specialty society representing more than 33,000 psychiatrists nationwide) and the attached list of consumer and provider groups are pleased to endorse the principle of nondiscrimination against the mentally ill and mental health services embodied in your bill to provide catastrophic health insurance coverage for elderly and disabled Americans (S. 210). As you proceed to respond to the legislative process and amend the bill we urge you to maintain that principle and not limit the bill to existing mental illness coverage limitations under the Medicare or Medicaid programs.

You have had an historic leadership role in helping to ease the stigma of mental illness and in fighting to protect those who suffer mental illness from financial catastrophe. We know the bill you help to enact finally will allow additional coverage for the elderly and chronically mentally ill populations and will allow their unfunded expenditures on mental health care to be included in the cap that triggers a catastrophic expenditure.

Again, the American Psychiatric Association and all of the listed groups thank you for introducing a bill that includes but is not limited to current coverage patterns. We are especially pleased with your floor statement articulating the poor coverage for outpatient care under the Medicare program.

We look forward to working with you and your staff as you further consider catastrophic health insurance for elderly and disabled Americans.

Sincerely,

Jay B. Cutler
Special Counsel and Director
Division of Government Relations

JBC/ES/jdc

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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

NATIONAL ALLIANCE FOR
THE MENTALLY ILL

NATIONAL ASSOCIATION OF
PRIVATE PSYCHIATRIC
HOSPITALS

ON CATASTROPHIC INSURANCE
COVERAGE

BEFORE THE

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

APRIL 8, 1987

On behalf of the American Psychiatric Association, a medical specialty society representing over 33,000 physicians; the National Alliance for the Mentally Ill, representing 680 affiliate members nationwide and 45,000 family members of seriously mentally ill persons; and the National Association of Private Psychiatric hospitals, representing over 250 non-governmental private psychiatric hospitals nationwide, we are pleased to submit, for the record, our views regarding catastrophic health insurance for those with mental illness to the Senate Labor and Human Resources Committee.

As the Committee hears testimony concerning coverage for catastrophic illness APA, NAMI, and NAPPH hope that you will carefully consider the mental health needs of our under 65 Medicare-eligible Americans as well as the over 65 population. Mental illness is like any other disease, it can be diagnosed, treated and can be costly both financially and in human terms. Mental illness is in some ways even more devastating than other diseases because both private insurance and federal Medicare and Medicaid programs do not adequately cover the costs of caring for the mentally ill. While catastrophic discussions have focused on acute care for physical illnesses, we should not forget to include chronic disabling diseases, such as schizophrenzia or severe depression, in the catastrophic debate. These diseases are as catastrophic as any physical illness, and in many instances, much more catastrophic.

Our testimony focuses on the extent of the need for mental health care; the cost-effectiveness of treatment of mental illness, discriminatory health insurance coverage for care of the mentally ill, and suggestions for improving psychiatric services under any catastrophic proposal.

Mental Illness and Addictive disorders

According to the Institute of Medicine (IOM) report "Research on Mental and Addictive Disorders", 15% of the population suffers from serious mental disorders at any one time. During their lifetime an estimated 3 million people will develop schizophrenia. It is important to note that we are talking about the treatment of a disease -- mental illness -- not the health/happiness/achievement of potential/social welfare services. Treatment for mental illness may be as aggressive as many life saving techniques. Direct costs of mental illness were estimated to be $33.4 billion in 1983.

To be more specific about the biological nature of mental illness, within the past few years exciting new breakthroughs in the treatment of mental illness have significantly changed not only our understanding of the causes of mental disorders, but have also given us the ability to effectively treat such disorders. For example, through recent research we have attained the capacity to effectively treat more than 85% of all severe depressions using drugs and psychothearapies. We have verified the existence of a genetic component to psychoses, and determined that environmental events may trigger one's inherited risk or predisposition for a given disorder. We have also refined techniques for diagnosing mental illness, which permits treatments to be tailored specifically to a patient's needs and ensures comparability of results in clinical research. Finally, we have gained a capacity, through techniques such as positron emission tomography and nuclear magnetic resonance, to observe biochemical activity in the conscious brain, and define discrete areas of the brain that may be defective in certain illnesses. Although there have been tremendous advances in the diagnosis and treatment of mental illness in recent years, psychiatric benefits under Medicare and private insurance remain in the dark ages.

The elderly population is growing and will represent a larger proportion of the general population (20%) in thirty years. Many elderly people have more than one health problem and may need more than one type of health care provider. Estimates indicate that some 15-20%, between 3 and 5 million, of our nation's more than 25 million older persons have significant mental health problems. Moreover, in 1982 those persons over age 65 accounted for just over 10% of the U.S. population, but 17% of deaths by suicide. Despite many mental health needs, the elderly population are denied adequate treatment because of discriminatory "caps" imposed on psychiatric care under Medicare.

It is also critical to point out that older Americans are not the only persons eligible for Medicare. There are hundreds of thousands of young Americans who are also eligible for Medicare through the Social Security Disability Insurance Program. Many of these persons suffer from serious mental illness, which makes it very difficult for them to work, and therefore, they become eligible to receive SSDI. It is these most vulnerable Medicare beneficiaries, who will need care periodically throughout their entire life, that are most hurt by the severe restrictions in the inpatient and outpatient psychiatric benefits under Medicare. The costs associated with the care of the chronically mentally ill can easily reach catastrophic expenditures, especially when work is not possible. These people can also be expected to live a normal lifespan.

Cost-effectiveness of Mental Health Care

Many studies have documented the offset effect -- a reduction in health care utilization when mental health services are provided. For example, one recent NIMH study of Aetna Life Insurance Companys claims from 1980-83 for enrollees in the Federal Employee

Health Benefits Program compared overall health care service use by those families using mental health services versus those families not using mental health services. Prior to the initiation of mental health treatment, use of overall health services rose gradually for three years with a sharp increase during the six months immediately preceding mental health treatment. Once mental health treatment was initiated, overall health use fell, and the greatest decrease in health utilization occured for persons over age 65. Overall, general health use cost $493 per month for the first six months just prior to initiating mental health treatment and $137 per month three years after treatment. The additional cost of mental health treatment was $13.96 per individual covered by the plan. The authors of the Aetna study caution that interpretation of other data over short periods of time may mask the dramatic nature of changes in health care service utilizaton after mental health treatment commences.

Limitation in Coverage of Psychiatric Care

Under the current Medicare Program outpatient benefits are restricted to $250 annually after coinsurance and deductibles. Inpatient care in a psychiatric hospital is limited to 190 days per a beneficiary's lifetime. Both these provisions have not been changed since the inception of the Medicare program in 1965. These discriminatory benefits do not only have a devasting impact on Medicare beneficiaries who need mental health services, but many private insurers have modeled their coverage after the Medicare program's psychiatric benefit structure. For example, a survey conducted by APA of 300 insurance plans pubished In 1983 indicated that although all plans have some level of coverage (inpatient and/or outpatient) for mental illness, only 6% of the plans had outpatient and inpatient coverage for mental illness comparable to that for physical illness. For these reasons, both Medicare beneficiaries and those persons with private insurance are greatly at risk of having large out-of-pocket exenses if they or a family member suffers from serious mental illness.

As pointed out earlier, the advances in the diagnosis and treatment of mental illness, have been substantial since the beginning of Medicare in 1965, however, the restrictions in the psychiatric benefits under Medicare have not been revised. Medicare, for instance, was passed at a time when most patients were hospitalized in state mental hospitals -- far from their homes and without hope of discharge. Now there are many alternatives including private psychiatric hospitals and multiple outpatient psychiatric medically necessary treatments. The continuation of 190 day lifetime limit prevents Medicare beneficiaries from receiving the needed care in the most appropriate setting. In addition, the outpatient benefit of $250 annually was put in place in 1965 and has not been increased. The benefit is presently worth $60 in constant dollars. Inadequate coverage for the full continuum of services needed by serious mentally ill pesons creates incentives for inappropriate care which in the long term proves more costly to Medicare program and society at large. For example, coverage for partial hospitalizaiton -- an intensive, rehabilitation/habilitation outpatient sevice -- may prevent more costly inpatient care or could shorten a patient's length of stay in hosital. It is evident that the psychiatric benefits under Medicare have not kept pace with the advancement in the delivery of psychiatric care. The time has come to allow the mentally ill who are Medicare beneficiaries the same coverage as those persons suffering from physical illnesses.

Recommendations

As the Labor and Human Resources Committee deliberates on catastrophic health insurance, we urge the committee to carefully consider the mental health needs of the Medicare beneficiaries. It is essential that funding for catastrophic care avoid the discrimination and stigma attached to mental illness. There must be non-discrimination within catastrophic health insurance for the treatment of mental and physical illness. It is critical that expenditures for mental health services are included in the "trigger" for catastrophic costs, and that the inpatient and outpatient limitations under Medicare be eliminated. It is very clear to the families who have dear ones who suffer from mental illness that mental illness is truly a catastrophic disease.

In closing, we believe that Senator Matsunaga's recently introduced bill, S. 718 co-sponsored by Senators Rockefeller and Melcher, is a first step in the direction of easing the burden for the elderly and chronically mentally ill. However, we hope that all discriminatory provisions regarding psychiatric coverage under Medicare will be eliminated as part of a catastrophic health insurance proposal.

APA, NAMI, and NAPPH thank you for allowing us this opportunity to submit our views and we look forward to working with the committee as you fashion a catastrophic health insurance plan for our Medicare beneficiaries. We have appended a letter we sent to you on February 3rd that we would appreciate being included with our testimony.

AMERICAN MEDICAL ASSOCIATION
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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

April 21, 1987

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

RE: Catastrophic Coverage
for Health and Long-Term
Care Needs

Dear Chairman Kennedy:

The American Medical Association is pleased to submit its comments concerning catastrophic coverage for health and long-term care needs for inclusion in the record of the April 8, 1987, hearing held by the Labor and Human Resources Committee on this issue. We have also included a copy of our recommendations for catastrophic health insurance coverage. We would be pleased to work with you on this important issue of mutual concern.

Sincerely,

James H. Sammons, M.D.

JHS/jmj
3026p

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Labor and Human Resources
United States Senate

RE: Catastrophic Coverage for Health and Long-Term Care Needs

April 22, 1987

The American Medical Association takes this opportunity to submit comments concerning the important issue of catastrophic coverage for health and long-term care needs. For many years, the AMA has advocated that catastrophic health care coverage should be included as part of a package of minimum benefits in all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional cost. In addition, even though the vast majority of persons would never actually use the catastrophic benefit, its mere existence would provide vital piece of mind.

In discussing catastrophic coverage, it is important to keep in mind that what constitutes a catastrophic expense varies from person to person -- based on individual financial resources. An expense that clearly would be catastrophic to a person relying solely on Social Security cash benefits might be manageable for an individual with a substantial annual income.

Catastrophic care expenses can be divided into two categories: acute health care costs and long-term custodial care costs. Effective steps should be taken now to assure all our citizens, including Medicare beneficiaries, that they will not become impoverished if faced with large acute health care expenses. Efforts should also be increased towards developing mechanisms to cover the potentially catastrophic expense of long-term care.

Acute Care Catastrophic Costs for the Elderly

AMA Proposal

Ideally, the addition of catastrophic coverage to current Medicare benefits should be accomplished as part of a broad reform of the Medicare program. With this in mind, we have develcped a new program, one that is fiscally sound and will assure health care services for the elderly into the 21st century and beyond. Our proposal would provide comprehensive protection, including catastrophic coverage. A summary of our proposal is attached to this statement.

Advantages of Private Insurance

The AMA recognizes that the catastrophic coverage issue is being addressed by Congress prior to long-term reform of the Medicare program because of appropriate concern for the risk of catastrophic expense faced by the elderly. While we support the intent of proposals by Secretary Bowen and others to expand Medicare to provide catastrophic coverage, we believe that such coverage is better provided through private insurance rather than under a government program.

The AMA believes that catastrophic coverage could be provided more efficiently and effectively by the private sector. Currently, about 70% of Medicare beneficiaries have Medigap policies. These policies already provide a considerable degree of catastrophic protection because they must meet the following minimum standards as a result of Congressional mandate:

- coverage of Part A inpatient coinsurance for Medicare eligible expenses from the 61st through 90th day of hospitalization in any "spell of illness";
- coverage of Part A inpatient coinsurance for Medicare eligible expenses incurred during use of Medicare's lifetime reserve days (91st through 150th day of hospitalization);
- upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for a lifetime maximum of up to 365 days; and
- coverage of Medicare Part B coinsurance up to at least $5,000 per year, subject to a maximum annual out-of-pocket deductible of $200.

We recognize, however, that gaps in Medigap coverage do remain. For example, the minimum standards for Medigap policies do not require that Part A coinsurance for the 21st through the 100th day of skilled nursing facility care be covered or that such policies provide coverage beyond the 100th day of a stay. The AMA is also aware that some Medigap insurers market expensive policies as well as duplicative policies that provide inadequate catastrophic coverage. To remedy these and other problems with certain Medigap policies, the AMA believes that the legislation creating these standards (Baucus Amendment) should be modified to require:

(1) higher loss ratios (e.g. 75% for individual policies and 85% for group policies);

(2) policies to clearly state that they do not provide coverage for nursing home care (unless they in fact do);

(3) insurers to offer coverage of additional benefits such as nursing facility care that go beyond the restrictive definitions of Medicare (e.g., intermediate nursing service) and unpaid physician services;

(4) insurers to offer policies that include a stop-loss provision limiting the insured's liability to a specified amount; and

(5) insurers to offer a "catastrophic only" coverage option.

Coverage for Indigent Elderly

Currently, about 20% of the elderly have neither Medigap nor Medicaid coverage. Most of these persons are poor or near-poor, but are not eligible for Medicaid. Innovative approaches should be explored for providing catastrophic protection for these persons. For example, vouchers could be provided to such persons to help them pay the premiums for private Medigap policies that include catastrophic protection. Alternatively, Medicaid's "spend down" provisions could be liberalized to allow these persons to become eligible for Medicaid after they incur a specified amount of out-of-pocket costs.

In any event, in order to provide coverage for this group, the use of general federal revenues will likely be necessary.

Imposing an additional Part B premium may force some beneficiaries out of the Part B program, exposing this vulnerable population to increased risk. It would be more equitable to provide assistance through a means-tested combined catastrophic and basic Part B premium.

Government-Funded Program

If Congress decides to provide catastrophic coverage through a government-funded catastrophic coverage program, the program should include the following elements:

- Coverage should be limited to acute health care costs;
- Benefits provided should be completely funded through new revenues;
- Revenues for such a program should be segregated in a separate account (not in Part A or Part B);
- The program should provide means-testing through a combination of a means-related additional premium for all beneficiaries, copayments scaling the out-of-pocket expense limit to a beneficiary's income and resources, and a tax on a portion of the actuarial value of Medicare benefits;
- Medicare coverage for SNF care should be expanded not only as to the number of days but also as to the type of nursing services covered;
- All Medicare beneficiaries should participate in the catastrophic coverage program; and
- Separate stop-losses should be provided for Part A and Part B expenses.

Long-Term Care Catastrophic Expenses for the Elderly

The great area of uncertainty concerning catastrophic insurance is the extent, if any, to which such coverage should include long-term custodial care. The average annual cost of nursing home care per patient is about $22,000. As a result, such care often generates catastrophic expenses. However, we do not favor inclusion of coverage for custodial services in a federal government-funded health program. We are particularly concerned that the 60% to 80% of the long-term care now provided to the disabled elderly by spouses, other relatives and/or friends would be shifted to taxpayers.

Broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives. Like Secretary Bowen, we believe that personal savings for long-term care should be encouraged by permitting tax deductible contributions to an Individual Medical Account and by allowing tax-free withdrawal of Individual Retirement Account funds for any health or long-term care expense. We also support the principle of a refundable tax credit for long-term care insurance premiums in order to stimulate the private market for long-term care. Other tax incentives should be explored to encourage family responsibility for meeting long-term care needs. In addition, barriers to prefunding long-term care benefits provided by employers to retirees should be removed. Finally, we believe that the federal government and the private sector should work together to educate the public concerning the absence of coverage for long-term care under Medicare and Medigap policies.

Catastrophic Coverage for the Non-Elderly

While the focus of the hearing was on providing catastrophic coverage for the elderly, the needs of the non-elderly should not be overlooked.

The AMA believes that adequate health insurance, including catastrophic coverage, should be furnished through the employment setting. Such coverage can and should be encouraged by limiting the deductibility of employer health insurance premiums only to employers who furnish health plans that provide such coverage and who participate in a statewide risk pooling program. Risk pools can make basic health insurance (including catastrophic coverage) available, at reasonable cost, for persons who are uninsured, underinsured or uninsurable.

While risk pools have been enacted in twelve states, the current exclusion under the Employee Retirement Income Security Act (ERISA) of self-insured companies from state regulation has created an insurmountable impediment to the establishment of effective state risk pools. We strongly urge appropriate amendments to ERISA that would allow states to regulate self-insured health plans for the purpose of requiring them to comply with state laws, including those requiring risk pools.

Workers who are laid off should have the opportunity to maintain employment-based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they paid while employed. In addition, we support the recently enacted legislation, P.L. 99-272, that requires employers to make group rate coverage available for terminated workers at the worker's sole expense for an additional 18 months.

Catastrophic coverage for low-income persons who lack employment-based coverage and who do not qualify for Medicaid should be provided either through vouchers for the purchase of private health insurance.

Conclusion

The AMA believes that providing coverage for catastrophic acute care costs can be achieved at small additional cost and should be aggressively pursued. We believe that such coverage can be provided more comprehensively by the private sector than under the expanded Medicare proposals. If Congress decides, however, to provide catastrophic coverage through Medicare, such a program should be limited to acute health care costs and should provide some form of means-testing. We believe that broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives.

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Catastrophic Health Insurance Coverage: AMA Recommendations

I. Medicare Elderly

The following recommendations concerning Medicare are intended to be short-term pending long-term structural modifications of the Medicare program necessary in order to stave off its otherwise inevitable fiscal bankruptcy.

A. Acute Care - Private Sector

- Catastrophic coverage preferably should be provided through private insurance rather than under a government program.
- The Baucus Amendment (Section 1882 of the Social Security Act), which specifies requirements for Medicare supplemental coverage, should be materially strengthened to assure meaningful coverage:
  - insurers should offer full coverage policies that include a stop-loss provision limiting the insured's liability to a specified amount, and offer a "catastrophic only" coverage option.
- Vouchers or tax credits should be used to help the 15% to 20% of the elderly who have neither Medigap nor Medicaid coverage to pay the premiums for private Medigap policies that include catastrophic protection.

B. Acute Care - Public Sector

In the event that the private insurance industry does not respond to offer satisfactory catastrophic coverage, then an expansion of Medicare should be considered with the following principles:

- All Medicare beneficiaries should participate in catastrophic coverage;
- Coverage should be limited to acute care costs and benefits provided should be funded through new revenues; and
- The program should provide means-testing through a combination of a means-related additional premium for all beneficiaries, copayments scaling the out-of-pocket expense limit to a beneficiary's income and resources, and a tax on a portion of the actuarial value of Medicare benefits.

C. Long-Term Care (Private Sector Coverage)

- Personal savings to pay the cost of long-term care should be encouraged in the following ways:

(1) by permitting tax deductible contributions to an Individual Medical Account; and

(2) by allowing tax-free withdrawal of Individual Retirement Account funds for any long-term care expense.

- In order to stimulate the private market for long-term care insurance, a refundable tax credit should be allowed for long-term care insurance premiums.
- Barriers to prefunding long-term care benefits provided by employers to retirees should be removed.

II. Working Population

Adequate health insurance providing specified minimum benefits, including catastrophic coverage, should be furnished in the employment setting. Such coverage should be encouraged by limiting the tax deductibility of employer health insurance premiums only to employers

— who furnish health plans that provide the specified adequate benefits and catastrophic coverage, and

— who also participate in a statewide risk pooling program.

The development of a statewide risk pooling program is essential to make coverage available to high-risk individuals, uninsured and underinsured individuals and small employers. All insurers, including the self-insured, should be required to participate in such pools. Necessary amendments to ERISA should be made in order for the State to create effective pools.

III. Medicaid and Near Poor

State Medicaid programs should provide uniform benefits to afford comprehensive protection including catastrophic coverage, with full "wrap around" coverage for the Medicare eligibles. Access to a wide range of provider and physicians should be assured through equitable reimbursement levels.

Catastrophic coverage for low-income persons without employment-based coverage and who do not qualify for Medicaid should be provided either through vouchers for private insurance or a Medicaid program expanded to cover those in need.

Statement to the
Senate Labor and Human Resources Committee
by the
American Veterans Committee
on the subject of
"Catastrophic Health Insurance"

March 3, 1987

The American Veterans Committee appreciates the opportunity to have its views brought to the attention of the Committee on the urgent question of "catastrophic health insurance."

AVC is a national organization of veterans of the United States armed forces, organized during World War II, which also includes veterans from World War I, Korea, and the Vietnam War.

The AVC is very much concerned about the current situation of health care in our country. The United States is the only industrialized nation in the world that has no system for guaranteeing health care for all. AVC has long been on record in favor of a national health insurance that would see to it that every American has the health care that he or she needs.

AVC's National Affairs Platform calls for:

"1. Increased Federal expenditures for research in the prevention and care of illness.

"2. Expansion of medical insurance and group medical care plans, including a plan for national health insurance.

"3. Expansion of public health facilities and services, hospitals and nursing homes, without regard to race, color, ancestry, national origin, religion or sex."

We have a population of aging Americans. The aging population is the fastest growing population in the nation. U.S. Census Bureau statistics for the year 2000 show 35 million people over 65 and 5 million over 65. By 2000 two out of every three males over the age of 65 will be veterans. Yet our health-care provisions have not taken account of this demographic reality. For veterans this has become a startling reality with the recently imposed limitations on the availability of the VA hospital system to veterans.

A 1985 Report based on the 1983 Survey of Aging Veterans indicated that two-thirds of veterans experience limitations in their activities due to disability or poor health, and it was urged that the VA should plan for those veterans over 75. These statistics reveal the extent of the problems of the aging veterans population. But that VA system which veterans have traditionally counted on will not be there for them--unless their illnesses are service-connected or they pass a means test.

This means that hundreds of thousands of older veterans who would not have had to seek health care services will now have to turn to other sources. Even if their incomes are above the poverty level, if they are not employed or do not have good private health care insurance plans, they find themselves out in "no-man's land." They, like their counterpart non-veterans, will find themselves vulnerable to the "catastrophic" impacts of serious and long-term illnesses which beset the elderly and which drain their meager resources and wipe them out financially.

Furthermore, there is strong evidence that the safety net provided by the Medicaid program is full of holes. It is available to less than 50 percent of the population living below the poverty level. Numerous studies have indicated that the amount of health care received by the insured population and the uninsured population is striking. Those who need health care most often are the ones least likely to get it under current laws and regulations.

Therefore, the Administration's proposed cuts in Medicare and Medicaid are irresponsible and can only exacerbate an already horrendous situation. When the AMA, the American Nurses Association, the Federation of American Health Systems, and the American Association of Retired Persons, get together to protest these proposed cuts in the Medicare-Medicaid programs, it is time to pay attention.

When the Department of Health and Human Services held hearings around the country on Secretary Bowen's proposals for the elderly to be able to meet the costs of "catastrophic illness," AVC's National Affairs Chairman Ben Neufeld testified in Oakland. We are attaching his detailed testimony to this Statement.

Essentially, AVC supports modifications to the Medicare porgram to make it more sensitive to the needs of beneficiaries with high-cost health problems. AVC does not, however, support the concept of a Medical IRA, primarily on grounds of financial impact. Most important, we urge full attention and relief be given to the health care needs of persons with low incomes, and those with no health insurance, people for whom relatively low costs for health and hospital care are "catastrophic."

Two major criteria must be used in developing such a program. They are:

-- Fairness. It must be, and appear to be, of help to all members of soceity who need help in meeting health care expenses, in proportion to their need.

-- Universality. It must be available to all persons in such need, wherever in the country they live. Unlike the present Medicaid program, your solution cannot be dependent upon state largess, and we believe your Committee should recommend a wholly-Federal program. Some states have shown that they will provide only the most minimal program; states have also demonstrated that they will use their political power to prevent imposition of the Federal penalties prescribed by law as inducements to them to implement programs.

It must be emphasized that any serious proposal must include protection for older Americans for long-term care, such as nursing home care. Neither lower nor middle income families can finance nursing home care, with annual costs averaging $22,000 a year. Any plan for "catastrophic health insurance" must include provision for elderly veterans and non-veterans who must draw upon lifetime savings (if they have them) to finance the expensive long-term care often needed in the so-called "golden" years. Both acute care and long-term care costs are truly "catastrophic" for the older generation. It is incumbent for the nation to address these unmet problems.

We owe Secretary Bowen a debt for opening up this issue at a time when the health and well-being of millions of Americans is being jeopardized by the lack of adequate private and public health insurance. While Dr. Bowen's proposals are welcome, they do not go far enough to meet the problem. We urge the Congress to enact the needed legislation so that elderly Americans with lower and middle income resources may receive the amount and kinds of health care that they need.

Statement of the

American Veterans Committee (AVC)

1735 DeSales street NW Washington, DC 20036 202 639 8886

Before the

Private/Public Sector Advisory Committee on Catastrophic Illness
Department of Health and Human Services

31 July 1986

Presented by

Ben Neufeld Member, National Board
Chairman, National Affairs Commission

2008 Linda Flora drive Los Angeles, California 90077 213 471 4032

I am Ben Neufeld, a member of the National Board of the American Veterans Committee (AVC). Avc is a national organization of veterans of the United States Armed Forces, organized during World War II and including also veterans who served during World War I, Korea and Vietnam. Our first national convention was held just forty years ago.

We appreciate the opportunity to participate in this forum. Our statement will touch upon the two matters mentioned in the general description of Secretary Bowen's proposals circulated by the Department and then discuss the nature of "catastrophic illness".

First, however, we would point out that this series of forums would not have been necessary - certainly not in its present form - if the United States had some form of national health program, a mechanism through which all Americans would be assured access to health care and the means of paying for it without regard to the circumstances of any individual patient.

Of the Secretary's proposals, the first concerned the Medicare program and modifications to make it more responsive to catastrophic illness defined in terms of the length of a period of illness, therapy and rehabilitation. This is a good idea. We have never been happy with the need for private, outside insurance to cover a significant portion of what Medicare was advertised as providing for the elderly person. As an alternative use of money now spent on Medigap insurance premiums, the idea of buying "deductibles insurance" or insurance for non-covered services makes sense. Of course, it may be a while before such insurance is available at reasonable cost for appropriate bundles of services. Long-term care and dental care are available only for selected groups now; the costs are high and the dental benefits are largely packaged for young families. So, more work will need to be done before specific alternate premium ideas can be evaluated with any precision.

Another alternative which has been under discussion for some time should also be explored: broadening the services which are included in the Medicare package, particularly dental services, prescription drugs and intermediate-level long-term care. Each of these can cause a major drain of the resources of an elderly person and his or her family. We call upon the Department to publish such actuarial information as it has and can develop on these three services so that we and all interested parties can analyze it and offer recommendations for Federal and other action.

An aspect of the Secretary's proposal for Medicare modification particularly worthy of mention in this age of reducing hospital stays is the reduction of coinsurance for skilled nursing care. One reason we consider this important is that it should reduce confusion about what Medicare will do for a beneficiary. Another is that it should make more apparent than it is now what Medicare does not do with respect to long-term care. Most important, of course, is that, while skilled nursing care is a need for many older patients, it is a resource in short supply in many communities; this recognition of the need may help expand the availability of such care. The economics of long-term care are such that relatively small differences in reimbursement seem to have relatively large consequences.

The other of the Secretary's proposals is the Individual Medical Account (IMA). Our National Board discussed the concept some years ago and rejected it, and we still find in the idea not enough positive aspects to warrant the tax loss to the Treasury and our support. Let us set forth our objections.

First, the IMA would, like the familiar IRA, have a maximum contribution every year. Whether this is expressed as a flat dollar amount or as an amount related to a person's maximum deduction deduction from wages or salary under FICA, those with the least available income would least be able to take advantage of the shelter and least be able to finance their health care needs. That is, the IMA would benefit the middle class without providing commensurate benefit to persons of lesser income, those who most need the assistance. Thus, it is not, as is suggested, an across-the-board partial solution to the potential financial impact of health costs.

Second, the IMA as described by Dr Bowen would be used to pay for long-term care. The present cost of such care is estimated to average $35,000 per year, including both skilled and lower-level care in a facility. Home care generally represents a lower total cost and a lower cost per patient, but this is true largely because it is intermittent. Unit costs, however, are not greatly lower than equivalent care in nursing homes for many services. With the cost to the patient as the standard, then, the amount of money available to pay for long-term care would not buy very much care unless the central depository could count upon continued high interest earnings. In this sense, it could fall upon hard times just as the Hospital Insurance Trust Fund has, to the detriment of its beneficiaries.

If the IMA deposits, including both worker deposits and interest earnings, are to be available also to pay for other kinds of health care, then predictability is even further compromised.

Third, Secretary Bowen's description of an IMA is fairly straightforward. However, Peter Ferrara of the Cato Institute has devised a far more complex administrative scheme relating deposits, earnings and expenditures to Medicare utilization, deductibles and coinsurance and to cash withdrawals. This scheme reverses the simplification in the Medicare modifications proposed by the Secretary and make it difficult for an individual to plan utilization of the IMA and Medicare benefits. There is also some possibility that the IMA will be able to work only on an annual cycle, at least as far as deposits are concerned. Because illness and disability do not respect calendars, this could further disrupt understanding and utilization. We do not see simplification as a goal in itself, such that benefits should be dropped to enhance understanding, but, other factors being equal, the simpler program is the more desireable.

Finally, we want to discuss what "catastrophic illness" is. The term literally refers not to the nature of an illness but to the cost of care for an illness. Some illnesses with catastrophic effects do not involve catastrophic costs of care. At one time, the subject was known as "the catastrophic cost of illness.

When it became necessary to define the term quantitatively, however, the insurance people and academic researchers tended to use themselves as standards and to establish levels of cost that would be catastrophic to them, given their own personal and family insurance coverage, employment-related health benefits, assets and willingness to reduce their own standards of living. The result is that catastrophic or "major medical" coverage becomes effective only after a deductible of ten or twenty five or more thousands of dollars, the higher the deductible meaning the lower the premium. Notice, however, that we are talking about multi-thousands of dollars as the threshold.

But, consider that not all people who are likely to require care of catastrophic cost are regularly employed in places where health insurance is offered. Many low-income people work where only the most basic health insurance benefits are available, at considerable cost. Right now, there is a significant population which lost its coverage when it lost its employment. And, the long-term unemployed and even many employees of marginal business and industrial firms and household employees have no access at all to insurance at affordable prices. For them, the threshold is much lower.

For some of these people, Medicaid may be available. With cutbacks in Federal and state funding, however, the Medicaid-eligible population has been shrinking, at different levels in different states.

Also, for some of these people, a health care expenditure of one thousand dollars may be beyond "catastrophic". The practical threshold may be only a few hundred dollars - if the provider will accept small payments over time.

Furthermore, Medicaid reimbursements in some states are so small and slow and the paperwork said to be so burdensome that patients who have Medicaid coverage are not welcome in the offices of some providers, making spatial access a more important factor in receiving care than ability to pay. This is a matter to which this Committee should devote some attention.

To maintain perspective, we remind the Committee that it was only with the creation of the Medicaid program that the term "medically indigent" came into use.

It describes those people who, although they have low incomes, are able to meet all of their needs until they incur major health care costs. These "medically indigent" people could be helped with their health care obligations even though they were not recipients of financial grants under one of the Federal-participation assistance programs. In other words, in 1965 there was recognition that catastrophic cost of health care involved costs lower than thousands of dollars for some people. Still, state coverage of the medically indigent was made voluntary while coverage of those receiving aid under the public assistance categories was made mandatory. Only a few states covered the medically indigent at first, but the number increased gradually until the last few years, when budget crises started to cause states to restrict Medicaid in various ways, including dropping the medically indigent population altogether.

But, the problem remains. We therefore suggest that your Committee specifically define its mandate to include the development of guidelines that will permit the Secretary to create and evaluate proposals for having the catastrophic cost of illness covered by programs that will truly serve families of modest and low income and those who lack access to affordable insurance.

It is vital that you do this quickly, for two reasons. One is that you do not want to run out of time yourselves and you will probably want to collect and study more hard data and opinions before you submit your final report to Dr Bowen.

The other is that, even as you are conducting your own study, others in the Department are preparing legislative and regulatory proposals that would further restrict the availability of Medicaid assistance. We refer you to the New York Times of 13 July. The story does not say whether the Health Care Financing Administration (HCFA) or some part of the Office of the Secretary is leading this effort, but it suggests that some old issues, once resolved, are being reopened in order to reduce the budgetary impact of Medicaid, even at the cost of impoverishment of some portions of our society. This is something which AVC, and, we think, Americans generally emphatically reject.

AVC, having urged you to undertake more work which will be perceived as unwelcome by some with whom you have to cooperate, offers to try to be of assistance if you call upon us for our help.

Rehabilitation Institute of Chicago

345 East Superior Street, Chicago, Illinois 60611 (312) 908-6000 Writer's direct dial number

Henry Betts, M.D.

Vice Chairman and Medical Director

for the

Rehabilitation Institute of Chicago

on

Catastrophic Health Insurance

for the

Senate Labor and Human Resources Committee

April 8, 1987

Senator Kennedy, I would like to take this opportunity to thank you for your interest in the issue of catastrophic illness, and express, at the same time, my hopes that a solution to this tragic dilemma may soon be forthcoming.

The recommendations which follow are the result of what we at the Rehabilitation Institute of Chicago see on a daily basis and reflect the experiences of the physicians and staff of the nation's leading facility for research, teaching, and treatment of men, women and children experiencing the effects of a wide range of severe physically disabling conditions.

RECOMMENDATION #1

1. That any and all initiatives in relation to coverage for catastrophic illness do not apply age as an indicator for when they become effective.

Discussion:

Throughout its thirty three year history, the physicians and staff of the Rehabilitation Institute of Chicago have dealt solely with patients whose cases can only be considered medically, socially and economically catastrophic. Over the past decade, for example, the Rehabilitation Institute, a member of the federally designated Midwest Regional Spinal Cord Injury System and a research and training center for brain trauma and stroke designated by the NIDRR, has treated more than 3,500 cases of Cerebrovascular Accident; more than 2,000 cases of brain trauma; more than 3,000 spinal cord injuries; and more than 1,000 amputees. More than 85% of these individuals treated for severe disabling conditions are under age 65. Any program which activates at age 65 or above would leave uninsured the population under that age which may fall victim to highway accidents, diving injuries, disabling conditions resulting from disease or illness, those born with congenital deficits and those who may not be eligible for coverage because of restrictive and/or exclusionary clauses presently common to a variety of American insurers.

RECOMMENDATION #2

2. That a universal cap of $2,000.00 be placed on out-of-pocket expenses for all Americans involved with catastrophic illness, regardless of age, employment status, or material circumstances.

Discussion:

As has been pointed out in numerous media reports, medicine has created its own "cycle of poverty" through he process by which individuals become liable for deductibles and cost sharing arrangements which can run into the tens of thousands of dollars. To be eligible for state financial assistance, certain guidelines must be met. While these vary from state to state, nearly all states require the liquidation of material assets; an income level which nears the poverty line; and the exhaustion of all other avenues of financial support. Usually, by the time a patient has finished with care for a severe illness, injury, or disease, they enter the beginning of the "medical poverty" cycle. If medical rehabilitation is required, they are pulled more deeply into it by the simple factor of accumulation of costs.

Further, the lifetime care costs of severe brain trauma, quadriplegia and some congenital deficits can often exceed half a million dollars per case. This figure is acknowledged in the insurance industry and by state and federal agencies. It encompasses attendant care, specialized housing requirements, transportation, recurrent medical and medically related expenses such as supplies and more. To expect any one individual, family or organization to cover such prohibitive costs runs counter to the administration's stated policy of establishing a "safety net" for those who fall between the "cracks" in the system.

RECOMMENDATION #3

3. That the definition of "catastrophic illness" be broadened to include congenital deficits, trauma, illnesses, diseases, and injuries resulting in the need for complex and/or long term

acute hospitalization, comprehensive physical rehabilitation, and nursing home care.

Discussion:

Presently the crisis in catastrophic illness coverage is defined by economic parameters, leaving little room for the medical implications of specific diseases, conditions, and infirmities to be discussed.

At the Rehabilitation Institute of Chicago, we have learned there are not only the clear and noticeable functional issues related to disability, there are also on-going medical and environmental issues implied by a disabling condition. Paralyzed persons, for example, face a lifetime of potential complications raised by matters of bowel, bladder, and skin management, as well as potential complications from scoliosis, psychosocial adjustment, and such seemingly remote factors as those raised by a largely inaccessible environment.

While all of these potential difficulties have economic corollaries a strict, financially defined model doesn't always take the complications into consideration. For example, while paralysis can easily be defined as catastrophic, decubitus ulcers may not be. However, medical practitioners know these are often complex and costly to treat, and may, in themselves, become both medically and thus economically catastrophic. Unless these implications are taken into consideration, catastrophic illness's long term effects may not be covered in any policy initiatives formulated solely on the basis of the cost of a single catastrophic incident.

RECOMMENDATION #4

4. That the Federal government act to limit the application by private insurers of exclusionary and other restrictive clauses.

Discussion:

It is no secret that competition has entered the field of health care, and that as competition for patients increases, providers are relying more heavily on business and managerial practices to survive.

One of these practices is to restrict the admission of patients who may be insured, but, whose policies carry exclusionary and restrictive clauses for pre-existing conditions. Such exclusions exist for a variety of diagnoses but ranking high among them are cancer, heart disease, circulatory disorders, neurological disorders, and chronic illnesses.

Where the insured, but excluded, individual is to turn for economic assistance is largely a matter of his or her own devices. Often it is not unusual for middle class Americans to suddenly have to turn to state Medicaid programs for assistance. As was mentioned in an earlier recommendation, this can only occur after the infirmed individual has exhausted all personal resources, and liquidated all assets.

By design, insurers deal with risk and risk pools. It seems only reasonable to expect that the drain on these pools will increase as the nation's population increases in longevity. In that case, a new approach to managing risk is required--one which will not penalize the infirmed in favor or what is fast becoming a preferred patient population.

I appreciate the opportunity to present our views and I hope you will let us know if we can provide any further information.

TESTIMONY
OF THE
CYSTIC FIBROSIS FOUNDATION
BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
REGARDING

CATASTROPHIC HEALTH INSURANCE
AND
ACCESS TO HEALTH CARE

Submitted by:

Robert K. Dresing
President and Chief Executive Officer
Cystic Fibrosis Foundation

March 11, 1987
Washington, D.C.

TESTIMONY OF THE CYSTIC FIBROSIS FOUNDATION BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

March 11, 1987

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Mr. Chairman and Members of the Committee:

On behalf of the Cystic Fibrosis Foundation, I want to thank you for the opportunity to testify on the issues of access to health care and catastrophic illness insurance. I offer my observations as the president and chief executive officer of the Foundation, but more importantly, as the parent of a twenty-year-old son with cystic fibrosis.

The Committee's longstanding support of health issues and the new widespread interest in catastrophic illness insurance have brought some of the nation's most unresolved health problems to the forefront. While much of the attention has been focused on the lack of access and affordability of health care for the growing elderly population, I would like to discuss a population that faces the tragedy of insurmountable health bills at a far earlier age.

Those who suffer from cystic fibrosis (CF) and their families are not unlike the elderly in facing extreme financial difficulties brought on by illness. The difference is that cystic fibrosis strikes young families before they even have the chance to build up assets, imposing a warrant of financial hardship and inadequate access to health care with the birth of a child.

This genetic disease occurs every time two of the 12 million Americans who carry the CF gene produce a child who inherits the gene from each parent. The disease causes the body to produce a thick mucus which clogs the lungs and impairs digestion, ultimately leading to death from repeated lung infections and lung damage. Improved treatments, including advanced antibiotics, pancreatic enzymes, and physical therapy, now enable half of the children with CF to live into their early twenties and beyond. Moreover, research on this disease holds the promise of new treatments in the future.

However, the cost of care -- especially when a family is excluded from the private, for-profit insurance system in this country, as many as them are -- can drain a family both emotionally and financially. The CF treatment regimen consists of up to 60 pills a day to aid digestion and prevent or control deadly lung infections, combined with daily physical therapy where children are clapped on the back and chest in various positions to try to dislodge the sticky mucus. With one or more two-week visits to the hospital for intensive antibiotic therapy, the average patient faces some $10,000 per year in medical costs. Hospital visits, physical therapy, medications, and use of oxygen increase as the disease progresses, bringing families $100,000 yearly medical bills that haunt their lives now and shape future lives of poverty. The magnitude of this health care burden is evident in the estimated $300 million bill that these families are somehow supposed to pay each year.

We could provide many individual examples of the tragedy unaffordable and unattainable health care has caused families with CF. Stories where parents have been locked into jobs because if they were to move they would lose health insurance coverage for their child. Cases where parents have been forced to stay home to care for their child, only to find that obtaining an individual insurance policy for an individual with CF is next to impossible. Their experiences include the painful discoveries of exorbitant insurance premiums reaching $1000 per month or more; pre-existing condition clauses excluding the very health care that is most needed; and long enrollment periods with no provisions for interim health care costs. These are the horrors that families face daily as they strive to find a way to afford the care their children need. If they look to the government for help, they find that the idiosyncracies of a particular state's eligibility requirements and coverage determines their fate. If they look to federal programs, supplemental security income or disability insurance, they find that their child must already be disabled and their family poor to qualify.

In essence, families affected by CF face a double-edged version of the proverbial "spend-down" associated with catastrophic illness. Not only must they sink to the level of poverty to receive government assistance, but they must watch helplessly while the disease progresses to the point where the child's health is "spent-down" so as to be legally disabled and eligible for assistance. The spend-down in finances dooms many families to a life of poverty that they cannot ever arise from; in a progressive disease like CF, the spend-down in health is even more final.

There is one group of individuals with CF that especially symbolizes the tragedy of catastrophic illness today. These are the young adults with CF -- those who have managed to survive into their late teens, twenties and thirties. For them, the victory of winning against this disease long enough to see adulthood is brought face-to-face with an insurance system designed to make them losers. Many of the CF adults who were covered by their parents' insurance policies find that at age 18, or 20, or 21, they are kicked out of the health insurance nest. In the few cases where they can be kept under their parents' policy, the price is high -- a forced "dependent" status for an individual who has more than earned the right to live as a young adult. To remain a dependent on their parents' plan, many CF adults forsake marriage or career plans, kept prisoners by the only insurance they can get.

For those who can or must work full-time, CF adults face rejection from companies that refuse to hire them for fear that they will negatively affect the group insurance plan. In some states, adults with CF face another rejection in aid programs. Even if they were covered as children under Crippled Childrens Services, they discover there are no provisions for them in adulthood.

Punished by an insurance system that faults them for surviving into adulthood, many of these young adults find themselves wishing for permanent disability just so that the burden on their families would be reduced. The pervasiveness of this problem was evident in the Cystic Fibrosis Foundation's most recent survey of CF families on insurance. The survey found that one hundred percent of the adults with CF had difficulty getting insurance, with thirty percent of these adults having absolutely no insurance. More than half of those insured described their coverage as inadequate.

The individual problems of both children and young adults with CF can appear insurmountable. But taken together, their experiences repeat a theme. They produce a set of four basic insurance needs that can be achieved with your leadership. By addressing these issues in catastrophic illness or access to health care legislation for the under-65 population, a majority of the financial hardships associated with cystic fibrosis and many other diseases could be eliminated. Therefore, the Cystic Fibrosis Foundation respectfully suggests the following as critical touchstones in your legislation:

1) ACCESS FOR THOSE WITH PRE-EXISTING CONDITIONS.

As a genetic condition, cystic fibrosis is present from birth. Therefore, our children and young adults do not have the luxury of joining a good insurance plan and then developing CF, a situation in which they might receive adequate coverage. Instead, the "pre-existing condition" label is attached to them even when they are in fairly good health, often leading to rejection from ever joining a traditional insurance plan.

2) REASONABLE PREMIUMS.

All the insurance plans in the world will not provide health coverage if the premiums are unaffordable. Those whose finances are already stretched with daily CF care generally find it impossible to pay the prohibitively expensive premiums associated with an individual insurance policy. Moreover, many insurance companies require that the premium be paid for an entire year before any costs associated with cystic fibrosis or any pre-existing condition are covered. Therefore, even families who might be able to afford the premiums are forced instead to use their money to pay for the health care needed now.

3) RECOGNITION OF ALL HEALTH CARE COSTS.

It is well known that insurance companies do not pay every cost associated with every health care condition. For CF, such costs go beyond deductibles and over-the-counter medications to include home health care, special diets, durable medical equipment, oxygen and medical services such as respiratory therapy. Any of these costs associated with the regular care of CF can be enough to deplete a family's assets. The alternative, not to provide care or supplies, is often a precursor to death. Many adults with CF cannot afford the antibiotics or pancreatic enzymes that would maintain their health. Legislation to improve access to health care must do more than address the hospital setting; it must address the many facets of good health care that can keep people out of the hospital.

4) NOT DEMANDING POVERTY OR TOTAL DISABILITY.

The current system of financial assistance for those who have already expended all their assets addresses the problem of catastrophic illness too late. Its victims are the middle and lower-middle classes, who do not have the resources to pay for a catastrophic illness entirely by themselves, but are not poor enough to immediately qualify for assistance. The creation of a plan that does not base eligibility on poverty or total disability could enable families affected by cystic fibrosis and other catastrophic illnesses to secure health care at a survivable cost.

Options for meeting the health care needs listed above have recently gained greater public awareness. Whatever solution is ultimately chosen, we cannot overemphasize the need to include the under-65 population as an integral part of that picture.

One option under consideration is a catastrophic illness risk pool system for the medically uninsurable. The Cystic Fibrosis Foundation enthusiastically supported risk pool legislation during the 99th Congress, despite the disappointing results that merely encouraged and did not require states to set up risk pools.

We would encourage any efforts to consider risk pools as a means for making health care accessible individuals with catastrophic illnesses. For such state-oriented legislation to be effective, however, it must mandate and provide support for state participation. We would also request that the Committee pay close attention to the cost of risk pool premiums, in order that the risk pools provide an actual alternative to individual insurance coverage costs. Ultimately, a sliding scale or subsidized premium may be essential for those who otherwise cannot afford to buy risk pool or alternative types of coverage.

Regarding other potential solutions, we ask only that the considerations raised above be implemented, for they will truly determine whether the current hardships of those facing catastrophic illness receive relief. Those who suffer from cystic fibrosis and other catastrophic health problems can individually show great strength and commitment in the face of illness, as seen in our children who survive into adulthood. But those same "fighters" cannot win against a health care system that overlooks their very health needs.

Mr. Chairman, the Cystic Fibrosis Foundation thanks you for your recognition of the need for improved access to health care for all Americans, especially the needs of children and young adults, and we support your efforts to find a solution that will make health care accessible to every American.

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STATEMENT RESPECTFULLY SUBMITTED
TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
THE HONORABLE EDWARD M. KENNEDY, CHAIRMAN

BY

ROBERT J. SLATER, M.D.
VICE PRESIDENT, MEDICAL AND COMMUNITY SERVICES
NATIONAL MULTIPLE SCLEROSIS SOCIETY
on behalf of the
COALITION FOR HEALTH INSURANCE AVAILABILITY

HEARING ON CATASTROPHIC HEALTH CARE

March 1987

Mr. Chairman and members of the Senate Committee on Labor and Human Resources, my name is Dr. Robert J. Slater. I am Vice President for Medical and Community Services at the National Multiple Sclerosis Society. We represent 450,000 people across the country through our national office and network of 140 chapters and branches.

I am presenting this testimony on behalf of the National Multiple Sclerosis Society and the COALITION FOR HEALTH INSURANCE AVAILABILITY, a coalition of more than 45 national organizations working to ensure that every American has access to quality health care and affordable and adequate health insurance. We represent millions of people with such conditions as arthritis, cancer, cerebral palsy, cystic fibrosis, diabetes, epilepsy, heart disease, mental retardation, mental illness, multiple sclerosis, sickle cell anemia, and tourette syndrome. (Attached is a copy of our coalition membership)

I wish to present our view of the catastrophic health care needs of people with disabilities, and a few recommendations.

For brevity's sake, I will not discuss the problems in depth. Nor will I provide detailed statistical data. However, I will gladly furnish you and your staff with any information requested.

THE GENERAL CIRCUMSTANCES OF THE CHRONICALLY DISABLED

The chronically disabled typically have large initial expenses associated with an acute onset phase, followed by the need for some form of sustained long-term care. Yet the majority of public and private financing progams are oriented to the acute illness or injury. To the extent that non-acute long-term needs are addressed at all, they are often treated as occuring during only the 18 months to 5 years after onset. Thus, those with chronic disabilities who have needs extending over two, three, four, five or six decades are a forgotten population.

While we applaud the Bowen Commission study and related efforts as a first step, we wish to underscore the point now being made by many that the Commission report emphasizes the acute stage and fails adequately to address the long-term, institutional and non-institutional needs so important to those under age 65 with chronic diseases and disabilities.

With many chronic diseases and disabilities, onset is in childhood or early adulthood. Yet their debilitating consequences are lifelong — either as a chronic disorder or with recurring episodes. There may or may not be known treatments, but there are no known cures. The pattern of treatment often involves periods of in-patient hospitalization — sometimes long-term — followed by periods of remission or stabilization with return to out-patient forms of treatment and rehabilitation. This cycle of recurrent acute service need, coupled with a need for ongoing maintenance care is truly catastrophic — both in terms of human suffering and economic costs — for the individual and his or her family.

PROBLEMS OF COVERAGE

What are the generic problems of catastrophic coverage? These tend to fall within two broad categories: 1) Unavailability of coverage; and 2) Problematic carrier policies and insufficient coverage.

1) Unavailability of coverage:

. Many people are ineligible for government insurance and benefit programs. If their condition had an early onset it may have interfered with their normal growth and development and with the acquisition of a servicable education. This in turn may mean that the individual has never as an adult acquired labor force attachments sufficient to establish entitlements through group insurance, compensation, and primary Social Security disability coverage. Even if the condition was first manifested during the teen years or early adulthood, the individual may still not have established a sufficient work history to meet government program eligibility requirements (e.g., for SSDI). In addition, medical eligibility criteria used in some programs often fail to take into account unusual attributes of particular conditions (e.g. subjective symptoms), thereby precluding benefits for people disabled by certain diseases.

. In at least one government program, Medicaid, many disabled persons are forced to undergo "spenddown" in order to become eligible. Thus, in many instances, this program does not avert catastrophy but rather necessitates it.

. State health insurance pools exist in fewer than a dozen states. Moreover, while the pools benefit some state residents, many with disabilities cannot affort the substantially higher-than-standard premiums.

. In the private sector, Blue Cross and Blue Shield plans, which are not-for-profit, policies and eligibility requirements vary greatly from region to region. It is irrational and unfair that the availability of coverage should be a function of geography.

. People with pre-exisiting conditions are precluded from obtaining individual coverage through virtually all private carriers. It is notable, too, that carriers automatically reject people with chronic diseases and disabilities independent of each applicant's particular health status (and hence insurance risk). Merely having one or another of a range of diagnoses makes one ineligible. For example, within the multiple sclerosis population, individuals may vary greatly in the course of their disease, its severity, in their consequent need for and utilization of services, and thus in the financial risk they present to the carrier. Yet an individual with "benign" MS will be rejected automatically, as will an applicant with severe progressive MS.

. Disabled individuals whose husbands or wives are covered under employer group plans are often precluded from spousal coverage due to their pre-existing conditions.

2) Problematic carrier policies and insufficient coverage:

Even where an individual with chronic disease or disability has coverage, he or she may be subjected to serious coverage limitations or other problems.

. Individuals who have paid premiums without utilizing their benefits to an unusual degree often find that once they experience onset of a condition and begin to submit larger or more frequent claims, they receive unconscionable premium increases. In effect they are punished for requesting the very benefits for which they have previously paid. For example, Mrs. K, of Yonkers, NY, must now pay $840.32 each month to keep her policy since being diagnosed with multiple sclerosis.

. As alluded to early in this presentation, many of the services most important to people with chronic diseases and disabilities — particularly those involving non-institutional and/or non-medical needs — are either not covered or are subject to serious caps and other use or payment limitations. Examples include the following:

- Nursing home care;
- Respite care;
- Personal attendant care (for such activities as bathing, dressing and feeding);
- Services that are considered "maintenance" rather than "therapeutic" (such as "maintanence physical therapy");
- Outpatient psychological and psychiatric services, including extended coverage on a par with that available for physical illnesses and disabilities;
- Long-term rehabilitation;
- Prescription drugs;
- Various supplies and equipment.

RECOMMENDATIONS

In light of the foregoing we urge that any plan to improve catastrophic coverage ensure availability and adequacy of coverage for all, and a sufficiency of appropriate, affordable coverage where it is now available but limited. Our specific recommendations for achieving these ends are the following:

. Federal legislative encouragement for the establishment of high-risk health insurance pools in the all states that do not now have them.

. Development of a Medicaid buy-in plan on a sliding scale for families whose incomes are low but still too high for current Medicaid eligibility.

. Development of standards and compliance mechanisms to close discriminatory loopholes in eligibility, cost, and range of coverage for people with chronic diseases and disabilities.

. Strict utilization controls involving peer review and case mangement to ensure the necessity, quality, cost, and appropriateness of care.

. Establishment of a board consisting of government, for-profit, voluntary, and consumer representatives to review government, private for-profit, and private not-for-profit insurance policies and practices.

. Development of incentives for the chronically ill and disabled and their families to use the least costly services appropriate to meet their needs.

. Formulation of mechanisms — perhaps appropriate tax incentives — to foster family responsibility.

. In special circumstances, the design and implementation of demonstration projects to test new delivery and funding options.

. Acquistion of better data to enable policy planners to meet the needs of the current population of chronically ill and disabled, and also to enable them to anticipate the needs of the rest of the population who may "age into" disability or long-term illness.

CONCLUSION

It is time that Congress faces the whole range of catastrophic health problems. Focusing on acute care, and primarily on the elderly, is not sufficient. Every American is at risk for health catastrophy.

Available, affordable, appropriate, and adequate are the watchwords for catastrophic health insurance coverage. Last year you reviewed legislation regarding high-risk health insurance pools for people with pre-existing conditions. Now you have an opportunity to do more through legislation on catastrophic care. Through pools, a Medicaid buy-in, and the coverage of certain catastrophic problems in long-term as well as acute care, Congress can now promote the development of policy which will lead to health care for all Americans and prevent both poverty and hopelessness for individuals and families.

COALITION FOR HEALTH INSURANCE AVAILABILITY

ACLD, Inc. An Association for Children and Adults with Learning Disabilities
Alliance for the Neurologically Impaired
American Association of Retired Persons
American College of Gastroenterology
American Diabetes Association
American Foundation for the Blind
American Liver Foundation
American Medical Student Association
American Speech-Language-Hearing Association
Amyotrophic Lateral Sclerosis Association
Arthritis Foundation
Association for Retarded Citizens
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MPS (Mucopolysaccharidoses) Research Funding Center, Inc.
Myasthenia Gravis Foundation
National Association of Children's Hospitals and Related Institutions, Inc.
National Association of Developmental Disabilities Councils
National Coalition for Health Care for the Poor and Minorities
National Consumers League
National Depressive and Manic Depressive Association
National Down's Syndrome Congress
National Easter Seal Society
National Head Injury Foundation
National Foundation for Illeitis and Colitis
National Huntington's Disease Association
National Mental Health Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Rehabilitation Association
National Society for Children and Adults with Autism
National Sudden Infant Death Syndrome Foundation
National Women's Health Network
Sickle Cell Support Association
Sick People Need Insurance (SPINS)
Sick Kids Need Involved People (SKIP)
Spina Bifida Association of America
Tourette Syndrome Association, Inc.
United Cerebral Palsy Associations, Inc.

NATIONAL MULTIPLE SCLEROSIS SOCIETY

1985 Statistics

on

What MS Costs

Information Systems Department
April 4, 1985

SOURCES OF DATA

Society Members and Chapter MS Case Census - January 15, 1985 Multiple Sclerosis Society records (Donor Membership and Renewal System - DMRS) to the extent received from Chapters.

Estimated Number of Known, Diagnosed Cases - These figures were developed from applicable prevalence rates multipled by general population served. Prevalence Rates (number of cases per 100,000 general population) developed by the Society's Medical and Community Services Department from data developed by Herbert M. Baum, Ph.D., Office of Biometry and Field Studies, National Institute of Neurological and Communicative Disorders and Stroke (NINCDS), National Institutes of Health, and Beth B. Rothschild, B.A., Booz-Allen and Hamilton, Inc., published in Annals of Neurology 10:420-428, November, 1981. Total 1980 population by Congressional District was taken from the Almanac of American Politics, 1984 by Michael Barone and Grant Ujifusa, increased by 1.053345% to approximate 1985 population.

Estimated Annual MS Medical Expenses and Estimated Total Annual Earning Losses for MS Households - The result of estimated prevalence of known, diagnosed cases multipled by cost factors developed by Robert P. Inman, Ph.D., Professor of Finance, Economics and Public Management, The Wharton School, University of Pennsylvania, from his paper, "Disability Indices, The Economic Costs of Illness, and Social Insurance: The Case of Multiple Sclerosis," August 1983, which summarizes research completed as a consultant under National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) Contract 1-N-4-2335. These data have been updated to approximate 1985 dollars. $2,663. is used as the average annual medical cost per person with MS and $8,962. is used as the average annual earnings loss per family.

Estimated Household Members Affected - The result of estimated prevalence of known, diagnosed cases multipled by the average household size by state from the Sales and Marketing Management Magazine Survey of Buying Power, 1983.

4/4/85

1985 NATIONAL MULTIPLE SCLEROSIS SOCIETY STATISTICS

STATE	SOCIETY MEMBERS	CHAPTER MS CASE CENSUS	ESTIMATED NUMBER OF KNOWN DIAGNOSED CASES	ESTIMATED ANNUAL MS MEDICAL EXPENSES IN 1985 DOLLARS	ESTIMATED HOUSEHOLD MEMBERS AFFECTED (INCLUDES THOSE WITH CASES OF MS)	ESTIMATED TOTAL ANNUAL EARNING LOSSES FOR HOUSEHOLDS WITH MS IN 1985 DOLLARS
ALABAMA	1,961	969	1,071	$2,851,592	3,020	$9,596,682
ALASKA	279	179	442	$1,177,142	1,282	$3,961,528
ARIZONA	1,743	1,197	748	$1,990,617	2,056	$6,699,177
ARKANSAS	1,592	717	618	$1,645,121	1,693	$5,536,451
CALIFORNIA	13,495	6,928	13,017	$34,663,728	34,885	$116,656,527
COLORADO	3,397	1,273	1,589	$4,232,786	4,196	$14,244,922
CONNECTICUT	2,496	1,838	3,077	$8,192,720	8,460	$27,571,595
DELAWARE	1,274	469	548	$1,218,696	1,272	$4,101,372
DIST. OF COLUMBIA	357	295	491	$1,307,510	1,208	$4,400,264
FLORIDA	10,158	7,500	7,500	$20,064,936		
GEORGIA	5,619	1,605	1,502	$4,000,768	4,267	$13,464,095
HAWAII	193	81	265	$706,467	844	$2,377,529
IDAHO	734	563	934	$2,488,562	2,663	$8,374,950
ILLINOIS	3,200	1,782	8,773	$23,362,781	24,214	$78,624,575
INDIANA	2,884	1,803	4,222	$11,242,754	11,737	$37,836,109

1985 NATIONAL MULTIPLE SCLEROSIS SOCIETY STATISTICS

STATE	SOCIETY MEMBERS	CHAPTER MS CASE CENSUS	ESTIMATED NUMBER OF KNOWN DIAGNOSED CASES	ESTIMATED ANNUAL MS MEDICAL EXPENSES IN 1985 DOLLARS	ESTIMATED HOUSEHOLD MEMBERS AFFECTED (INCLUDES THOSE WITH CASES OF MS)	ESTIMATED TOTAL ANNUAL EARNING LOSSES FOR HOUSEHOLDS WITH MS IN 1985 DOLLARS
IOWA	2,066	1,545	2,885	$7,681,876	7,789	$25,852,412
KANSAS	3,365	995	1,300	$3,461,962	3,432	$11,650,810
KENTUCKY	814	410	2,013	$5,361,757	5,698	$18,044,336
LOUISIANA	1,479	1,006	1,157	$3,080,086	3,331	$10,365,651
MAINE	2,471	893	1,237	$3,294,467	3,414	$11,087,123
MARYLAND	1,925	1,715	3,249	$8,652,268	9,097	$29,118,149
MASSACHUSETTS	8,348	4,521	5,680	$15,124,952	15,562	$50,901,172
MICHIGAN	7,946	5,314	10,132	$26,980,792	28,571	$90,800,548
MINNESOTA	3,130	2,973	4,484	$11,939,815	12,240	$40,181,984
MISSISSIPPI	549	336	693	$1,845,926	2,059	$6,212,238
MISSOURI	3,448	2,206	2,704	$7,201,224	6,441	$24,234,837
MONTANA	874	497	865	$2,304,451	2,328	$7,755,347
NEBRASKA	1,558	1,006	1,554	$4,138,640	4,165	$13,928,084
NEVADA	496	329	440	$1,172,442	1,180	$3,945,710
NEW HAMPSHIRE	1,878	689	1,013	$2,696,743	2,795	$9,075,558
NEW JERSEY	6,986	3,110	5,671	$15,101,643	15,935	$50,822,729
NEW MEXICO	1,196	664	358	$954,142	1,014	$3,211,047

1985 NATIONAL MULTIPLE SCLEROSIS SOCIETY STATISTICS

STATE	SOCIETY MEMBERS	CHAPTER MS CASE CENSUS	ESTIMATED NUMBER OF KNOWN DIAGNOSED CASES	ESTIMATED ANNUAL MS MEDICAL EXPENSES IN 1985 DOLLARS	ESTIMATED HOUSEHOLD MEMBERS AFFECTED (INCLUDES THOSE WITH CASES OF MS)	ESTIMATED TOTAL ANNUAL EARNING LOSSES FOR HOUSEHOLDS WITH MS IN 1985 DOLLARS
NEW YORK	12,141	8,583	19,315	$51,434,969	51,956	$173,098,083
NORTH CAROLINA	4,481	1,380	1,617	$4,302,364	4,497	$14,495,906
NORTH DAKOTA	808	711	718	$1,912,004	1,989	$6,434,615
OHIO	7,711	4,796	8.314	$22,140,648	22,781	$74,511,637
OKLAHOMA	1,567	434	832	$2,215,495	2,205	$7,455,978
OREGON	2,198	1,075	2,607	$6,941,839	6,752	$23,361,908
PENNSYLVANIA	13,323	4,579	9,135	$24,327,035	25,030	$81,869,655
RHODE ISLAND	1,052	537	938	$2,497,048	2,541	$8,403,510
SOUTH CAROLINA	1,961	510	859	$2,286,187	2,524	$7,693,881
SOUTH DAKOTA	761	439	760	$2,023,467	2,097	$6,809,729
TENNESSEE	3,490	1,025	1,263	$3,362,192	3,485	$11,315,045
TEXAS	3,167	1,882	3,913	$10,420,641	10,996	$35,069,391
UTAH	1,074	846	804	$2,139,908	2,587	$7,201,597
VERMONT	2,064	450	563	$1,498,208	1,558	$5,042,036
VIRGINIA	3,268	2,510	2,941	$7,831,217	8,205	$26,355,001
WASHINGTON	3,926	2,558	4,545	$12,104,325	11,909	$40,735,620
WEST VIRGINIA	991	350	1,072	$2,855,546	2,992	$9,609,990
WISCONSIN	2,619	2,583	5,209	$13,872,482	14,378	$46,686,138
WYOMING	929	493	465	$1,237,926	1,292	$4,166,088
NATIONAL TOTAL	165,442	85,764	151,191	$402,620,409	413,458	$1,354,969,622

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

1300 19th Street, N.W., Suite 501, Washington, D.C. 20036 (202) 822-9459

STATEMENT OF
FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN OF THE NATIONAL COMMITTEE
TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO
THE COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE

REGARDING
CATASTROPHIC HEALTH INSURANCE

APRIL 8, 1987

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four million members, most of whom have little or no catastrophic health insurance protection. I commend you, Mr. Chairman, for holding these hearings to search for solutions to overcome the financial tragedy that a catastrophic illness can cause older Americans. Thanks to your concern and that of your colleagues, I believe we can look forward to serious catastrophic health insurance legislation in this Congress.

I want to thank you, Mr. Chairman, in particular, for taking the initiative at the beginning of this Congress to introduce S. 210 which would provide catastrophic health insurance for doctor and hospital bills. While S. 210 is limited in scope, you recognized that a step was needed to put this important issue on the legislative agenda.

I am pleased to learn that you now wish to expand your legislation to include prescription drugs and other important elements of catastrophic health care coverage. My statement emphasizes the need for catastrophic health insurance legislation to cover prescription drugs and long-term care. While there is logic to your proposal to include catastrophic health insurance under the Public Health Service, we believe that it makes more sense to expand Medicare. After all, Medicare is already the primary health insurance for older Americans.

It is not an exaggeration to say that Medicare has made the difference between life and death for countless thousands of seniors who might otherwise have delayed seeking care until a once treatable condition had become life-threatening. As vital as it is, however, Medicare does not cover a full range of medically necessary services. Sadly, thousands of individuals and families are reduced to poverty when illness strikes. To be forced into bankruptcy because of unmanageable health care costs is a true catastrophe. Protection against such catastrophic expenses is Medicare's unfinished business.

Mr. Chairman, as you know, this Congress is about to make a very important decision. Will Congress decide to tinker with the current Medicare system or will Congress take the bold step of comprehensive reform and expand Medicare to cover long-term care and prescription drugs? The President proposes a very limited expansion of Medicare to protect seniors against catastrophic hospital and doctor costs. Legislation introduced by key members of the House Ways and Means Committee, while better than the President's proposal, is similar in scope. However, an important bill has been introduced by Senator James Sasser (S. 454) which includes catastrophic coverage for long-term care as well as preventive exams, vision, dental and hearing care. Representative Pepper has introduced a similar bill, H.R. 65, in the House, which includes prescription drugs. We want to commend Senator Sasser for the leadership he has shown by sponsoring legislation which would bring such important coverage for seniors. We hope that you will consider this approach to catastrophic health insurance.

Assuring quality health care to all citizens who require nursing home care or extended home care or who depend on drug therapy certainly represents an important financial commitment. The National Committee fully appreciates the challenge you and your colleagues face. Yet we agree with Representative Pepper when he says that we cannot afford NOT to cover long-term catastrophic health care costs. This may well be the historic time to search our conscience and our coffers to come up with a solution.

A LIMITED PROPOSAL

President Reagan's proposal falls short of providing true catastrophic Medicare protection. Medicare beneficiaries face the catastrophe of bankruptcy because Medicare pays for less than half of the health care of seniors. Under the President's proposal, Medicare would pay for Medicare covered hospital and doctor expenses above $2,000. However, most people will already have spent a lot more for uncovered expenses such as nonassigned doctor fees or prescription drugs. Many individuals suffering from chronic illnesses, such as Alzheimer's disease or arthritis, do not need doctor and hospital care. They are more likely to incur catastrophic expenses related to nursing home care, home health care and/or prescription drug expenses. The President's proposal would not help these victims.

Among the thousands of letters received each week by the National Committee to Preserve Social Security and Medicare are numerous pleas for help with health care costs. Some have unpaid medical bills which often total more than two or three years' income. Many individuals and families are confronted with total impoverishment when bills for acute or chronic care reach catastrophic proportions. It is no wonder that many seniors and their families are concerned for the future.

I recently received a letter from a National Committee member from Knoxville, Tennessee. This women's story is a tragic reflection of the inadequacy of Medicare's current coverage:

> I am writing to tell you about my husband. Henry has been in the hospital for 23 days. My son had to put him in a nursing home today... He has been bad for over a year. He has had two strokes. I have waited on him and me sick. See, I live by a pacemaker and can hardly walk because of arthritis. The doctor said I could no longer care for him because I coundn't lift him or give a bath or give him IVs so he had to go to a nursing home... We are both 74 years old and I feel God has been good to us both. He worked until he was 70 years and paid in Social Security ever since 1937. He sure wasn't lazy.... All of our life savings are gone now. Henry and I together got $831 Social Security. They (the nursing home) will take $562 of his and that will leave me $269 to live on, which sure will be rough going, me with this sickness I have. My medicine really costs ($80 a month). I'm going to try to get SSI and Medicaid, food stamps. My pacemaker check on the phone is $30 a month.

President Reagan's legislation would not help this couple pay for his care in the nursing home or for her prescription drugs. She might have been able to keep her husband at home if she had some physical assistance. After a lifetime of work and saving, this woman will now be permanently dependent on public assistance. In fact, the President proposes to help only 800,000 seniors a year or about 3 percent. It will more likely upset the other 97 percent to pay $60 a year more in premiums yet receive no additional benefit. Clearly, it is politically dangerous to offer such a limited proposal. Seniors expect greater vision and more tangible results.

COMPREHENSIVE CATASTROPHIC MEDICARE COVERAGE

At the beginning of this century, the most prevalent health problems of seniors were acute. Today, the most prevalent health problems are chronic, and the likelihood of having a chronic or disabling condition increases dramatically with age. An estimated 85 percent of Americans are underinsured against the catastrophe of long-term care. And few have insurance for prescription drugs.

Nursing home care. Probably the greatest fear held by older persons is to become so totally disabled that they must enter a nursing home for an extended period of time. Although only about five percent of the elderly live in nursing homes at any given time, about 20 percent of the very old are institutionalized. The fear of having to live a dependent life in an institutional setting is coupled with the enormity of the expense and drain on resources. The average person will deplete his or her resources in little more than three months at the rate of about $22,000 a year for nursing home care.

The misconception that Medicare covers nursing home care is still all too prevelent. Yet Medicare covers only two percent and private insurance just one percent of this nation's nursing home bill. While many older Americans are under the illusion that they are protected by Medicare and Medigap insurance, the devastating reality is that only after spending themselves into poverty does the public step in to help. Medicaid covers nursing home care for impoverished patients - the last resort for many families who must suffer the humility of seing their dependents supported by a welfare program.

Community-based care. Since the beginning of Medicare and Medicaid, public policy has been more directed to support of institutional care than community-based care. As important as is coverage of nursing home stays, it is equally important that any new catastrophic legislation not be biased toward institutional care. For every one frail person in an institution there are two equally frail people being cared for in the community. In addition to the very frail, many more seniors require some type of assistance with activities of daily living. Most are cared for informally by families, others by a combination of informal and formal support services. New policy should encourage community-based care by increasing support to families caring for their dependents.

For seniors themselves, home care has always been the preferred care, whenever possible. Families respond to this preference by performing 80 to 90 percent of the care given their dependent relatives. Still, there is a great need for formal home care services to complement family care. Our nation has a serious problem with home care. Medicare covers only limited, acute skilled nursing care, while coverage for homemaker and chore services is virtually non-existent.

The demand for home care has increased by 37 percent since the Medicare Prospective Payment System for hospitals was implemented in 1983. Yet Medicare is increasingly denying coverage for home health services. The General Accounting Office recently found that 86 percent of hospital discharge planners reported problems with home health care placements. Under an expanded health care system, home care should be made available through a comprehensive needs assessment and a care management system.

Adult day care is another important element in the continuum of care necessary to meet the growing need of aging members of our society. Only within the last decade has this type of custodial care gained acceptance. We currently have an estimated 1,000 adult day care centers in the United States providing service to between 10,000 and 15,000 disabled adults.

A recent study by the National Council on the Aging found the average participant of an adult day care center to be a 73 year old female living on a $478 a month income. She is living with family or friends. Half of the participants need supervision, one out of five have difficulty walking, and about one out of eight is wheelchair-bound. The average charge per day is $22. The indication is that adult day care participants are mentally or physically frail. While the participant receives both care and socialization, the family members receive respite from the stresses of providing care to a frail person. Adult day care can provide a place to bring the dependent family member from a few hours a week to enough hours to enable the caregiver to work in a job outside the home. With this type of support, the family is able to provide care longer and, therefore, postpone or prevent institutionalization.

Prescription drugs. Another example of the inadequacy of Medicare's coverage is the failure to pay for prescription drugs. For some older people, chronic, long-term care consists of taking the appropriate prescription drug. However, these prescriptions can be very expensive. It is not unusual for a person with a heart condition to spend more than $100 per month on medications needed to sustain life. Diabetes is another example of a chronic health problem which requires careful monitoring and access to insulin. If a diabetic cannot afford insulin, Medicare may eventually have to pay to amputate his or her leg. This individual may also end up in need of nursing home care -- thousands of dollars spent because a few pennies were "saved."

The heaviest use of prescription drugs is, understandably, among the older population. Older Americans are 2 1/2 times more likely to be taking three or more prescription drugs regularly than younger adults. Most seniors, an estimated two-thirds, take at least one prescription drug at any one time, and many take as many as four or five drugs a day. Unfortunately, Medicare covers only drugs used while the person is hospitalized or in a skilled nursing facility. Medicaid will only cover the costs of prescription drugs for the poor. Payments for drugs represent 20 percent of senior citizens' total out-of-pocket health care costs and average $340 per person per year.

FINANCING

Despite the desire of policy makers to protect Americans from the cost of a catastrophic illness, the Pepper/Sasser legislation is one of the few to have made a proposal on a scale sufficient to solve the problem. In an era of large government deficits, most worry that the American people would not support a new, costly government commitment. But this argument ignores the fact that the American people already pay for catastrophic illness.

Seniors and their families pay almost as much of their health care bill as Medicare, but only about one quarter through insurance premiums. The majority of private expense is in the form of Medicare copayments and uncovered expenses. Medicaid and other government programs pay for about 10 percent, mostly for nursing home care. If Medicare paid for catastrophic illness for seniors, Medicaid's resources devoted to senior citizens could be shifted to Medicare. Most seniors and their families could afford to contribute more to Medicare through premiums and taxes if they in turn received more comprehensive health insurance.

A major limitation to comprehensive catastrophic legislation is the shortsighted approach to financing. Some Members of Congress have expressed opposition to any proposal which is not "generationally neutral." They apparently mean that older Americans alone should share in the cost of expanding Medicare to provide additional services and that it is "unfair" for the working population to participate in the financing. Both the President and the Ways and Means Health Subcommittee impose additional premiums or taxes only on seniors to finance new Medicare coverage. This financing limitation ignores the fact that the problem of catastrophic health care costs for seniors is not generationally neutral.

Generations are interrelated and families do take care of their dependent relatives. Consequently, the pleasure and the burden of caring for individuals at the end of the life span is one that we all share. Family members help each other financially, physically and emotionally. The whole family, young as well as old, has a vested interest in knowing that fathers, mothers, grandfathers and grandmothers are being well cared for in their old age. It makes more sense to share the financial responsibility through a catastrophic insurance program than through the inefficient and dehumanizing method of bankruptcy and welfare.

By the time of retirement, individuals no longer have the resources to be able to finance all their health care. The financing of Medicare must begin while working. This is the overall principle for currrent Medicare financing. A young worker with a family, try as he might, will find it difficult to save for his health care protection when retired. And to expect seniors to pay for the full cost of health care will not solve the problem of catastrophic illness, but will continue to foster the problem.

Most senior organizations and some Members of Congress refuse to step forward and lead on the issue of financing. Senator Sasser and Representative Pepper are not afraid and neither is the National Committee. We endorse the financing proposals in the Pepper/Sasser bill to transfer some Medicaid resources to Medicare and to add additional contributions from beneficiaries. The National Committee also believes that it is necessary to control open-ended costs through health care delivery reform. The Pepper/Sasser bill proposes a capitation approach. Considering the Administration's interest in capitation, it is perhaps surprising that the President did not adopt the Pepper/Sasser approach to providing catastrophic care.

According to a preliminary Congressional Budget Office estimate, the cost of the Pepper/Sasser bill including prescription drug coverage would be about $65 billion a year. The National Committee proposes that seniors pay for approximately half of the cost of a comprehensive Medicare catastrophic package through premiums, deductibles and copayments. Seniors should finance the majority of their share through a premium.

Rather than deducting a flat amount from a Social Security benefit, however, the National Committee recommends a premium that is a percentage of the Social Security benefit. This would insure that all pay a fair share, but not more than they can afford. This financing mechanism is similar in principle to the payroll tax which is a percentage of earnings. If next year's $22.30 monthly premium was replaced by a premium equal to 15 percent of the Social Security benefit of Medicare eligible individuals, Medicare revenues would increase by over $20 billion. The average retired worker would pay about $73 a month (15 percent of $488), a little more than three times next year's projected premium.

Senior citizens currently pay about $40 billion a year out-of-pocket for Medicare deductibles and copayments and uncovered health care expenses. The National Committee recommends that Medicare cover all health care expenses and that Congress develop a deductible and copayment package that would reduce out-of-pocket liabilities by one-third to $10 to $15 billion a year. With a slightly higher premium, deductibles and copayments could be even less. Deductibles and copayments should be spread over hospital, doctor, nursing home, community-based care and prescription drug costs with an overall ceiling on out-of-pocket costs. Under this financing package, deductibles and copayments would average about $333 a year. Private insurers would probably be anxious to capture a $10 to $15 billion market and would consequently provide insurance packages to cover these deductibles and copayments.

Even assuming a 10 percent saving from health care delivery reform, the financing package does not come together without additional contributions from the whole population. The National Committee supports raising the Medicare payroll tax rate. Raising the tax rate from 1.45 percent to 1.6 percent would raise approximately $6 billion a year. Eliminating the wage base for Medicare payroll taxes, as the Pepper bill proposes, would raise an additional $7 billion a year. The National Committee is not opposed to increases in Medicare payroll tax revenues. However, we would also recommend the development of additional financing sources for Medicare that are more progressive and less a disincentive to employment. One suggestion is earmarking income tax revenues for Medicare. A one percent earmarked tax on all taxable income, for example, would raise about $19 billion a year. To the extent that seniors worked or had taxable income, they would also contribute through the payroll tax and earmarked income tax.

SUMMARY

Of all the legislation introduced to date, the National Committee believes that the best starting point for developing a Medicare catastrophic health insurance plan is the legislation introduced by Senator Sasser and Representative Pepper. This legislation offers the most comprehensive coverage.

Clearly we need to assure senior citizens access to a full range of health care services, including long-term care in a nursing home and prescription drugs. The financing of a Medicare catastrophic health insurance plan will undoubtedly be controversial. At the same time, financing is at the heart of the debate. Without additional financing, comprehensive Medicare catastrophic coverage will remain a fantasy. The National Committee hopes its financing proposals can be a catalyst for further debate and action on an agenda of vital importance for all Americans. It is time that we meet the challenge head on.

Before concluding, I would like to acknowledge the legislative contribution of other Members of Congress, who have made worthwhile proposals to expand Medicare or to ameliorate strict limitations on Medicaid eligibility for nursing home care. The details of some of these proposals should be incorporated into more comprehensive legislation. If action is not taken this year on a more comprehensive proposal, we would expect Congress to act on at least some of the proposals to:

* clarify eligibility requirements for Medicare home health care
* expand eligibility for community-based care under Medicare
* cover prescription drugs under Medicare
* prevent spousal impoverishment
* eliminate the requirement for 3-day prior hospitalization before coverage of skilled nursing care
* increase Medicaid nursing home personal allowance from $25 to $35
* cover adult day care under Medicare
* cover preventive examinations

This country spends 11 percent of its gross national product on medical care -- more than any other industrialized nation. Yet in comparison with other industrialized nations, we fall sadly short of providing comprehensive health care for our citizens. Because of the limitations of our health care financing, many seniors live with the constant threat of bankruptcy in the face of serious or long-term disability. Let this be the Congress which has the courage and the vision to provide affordable and adequate health care coverage to older Americans faced with a catastrophic illness. To do so would banish the fear of financial hardship from the lives of countless Americans.

Lieutenant Governor
Leo McCarthy
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TESTIMONY BY

LEO McCARTHY
LIEUTENANT GOVERNOR OF CALIFORNIA

TO THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
WASHINGTON, D.C.
APRIL 8, 1987

I am honored for the opportunity to testify today on an issue of vital importance to older Americans and public policy-makers -- the spiraling cost of acute-care illness and long-term health care.

Through nearly two decades in the California State Legislature, I was fortunate to have successfully authored numerous laws dealing with aging and long-term care. This legislation included creation of one of the nation's first adult day health care programs and multi-purpose senior services projects, key alternatives to warehousing our elderly in long-term care institutions.

More recently we fought and won a bipartisan battle for the most comprehensive nursing home reforms in the history of our state and perhaps the nation. I was privileged to lead a Senior Leadership Coalition that pushed the "Nursing Home Patients' Protection Act of 1985" to reality. I am proud California has been a leader in long-term care and aging programs.

Today's hearing focuses more specifically on the Reagan Administration's so-called catastrophic health proposal. I am compelled to characterize the plan itself as a "catastrophe."

What we really have here is a full measure of political hype, not what is represented by the Administration as the "last full measure of security."

Last month in California I joined forces with Bill Hutton, Executive Director of the National Council of Senior Citizens, to publicize some of the defects in the Reagan plan. Here are a few reasons why we labeled the Reagan plan a catastrophe:

- A far-too-high out-of-pocket expenditure of $2,000.
- Deductibles and co-payments that tax those who are ill.
- Continued restrictions on skilled nursing home care.
- No coverage for actual long-term care, respite or day care, or home health services, let alone any support for family care givers.

Moreover the Administration's plan will only provide direct benefits to less than one percent of the Medicare patients who reach their 61st day in a hospital.

The Reagan proposal does nothing for the 1.8 million senior citizens who now require long-term care or the one-out-of-five elderly persons who will eventually wind up in a nursing home some day.

At the same time the elderly are being socked with another increase in Medicare charges -- this year it's $4.92.

Medicare beneficiaries already pay $17.90 per month to participate in the program, and their costs would increase to $22.82 in order to fund Reagan's new proposal.

Senior organizational leaders throughout the country have called this scheme a bargain for the rich and a heavy burden for the majority of senior citizens who will have to sacrifice their savings before they can benefit from it.

Programs for the elderly have been consistently threatened since this Administration took office, the least of which has been a continuing increase in Medicare charges and co-payments.

But these Medicare cost increases might not be so bad if the benefits of this reform had universal application. In other words, let us not bandaid little co-payments here and billing problems there. All persons 65 years of age and over should clearly benefit from such a proposal.

All aspects of skilled nursing care should be included, especially since the prospective payment system -- effecting the diagnostic-related groups -- has further confused the difference between in-hospital care and nursing care.

Such a proposal also must address the ever-increasing need for proven cost-effective programs such as adult day health care and in-home support services.

Nationally-recognized programs like San Francisco's On Lok have proven time and again the cost-effectiveness of non-institutional day health care services.

A good health care system should be sensitive to the needs of the family caregiver who now provides nearly 90 percent of all long-term care services for their loved ones.

Our health care system for older Americans would have been bankrupt long ago were it not for these committed and caring families.

Financing must be based on principles of equity and efficiency, and any financing formula is going to be controversial. Already there is controversy on Capitol Hill -- and among the many senior organizations across the country.

I applaud proposals by Congressman Claude Pepper, Senator James Sasser and other legislative leaders who are genuinely attempting to deal with many of the pressing health care issues facing us all.

Without a doubt, whether at the state or national level, we all need to work together and focus our attention on a sound and workable financing mechanism that provides quality care for not only older Americans but for all of us.

(END)

STATEMENT OF THE

NATIONAL MEDICAL ASSOCIATION
BEFORE
SENATE COMMITTEE ON
LABOR AND HUMAN RESOURCES
ON
CATASTROPHIC HEALTH CARE

PRESENTED BY
JOHN O. BROWN, M.D.
PRESIDENT

APRIL 8, 1987
WASHINGTON, D. C.

Mr. Chairman, I am John O. Brown, M.D., President of the National Medical Association. We are very pleased to present our written testimony on a subject that is very important to each of us - protecting the American public against catastrophic medical expense. First, I would like to describe the organization I am representing today: The National Medical Association (NMA). The National Medical Association was founded in 1895 by Black physicians in an era of general hostility toward Black professionals. Unwelcomed in the national body of physicians, the NMA was founded to encourage the professional development of minority physicians in the interest of providing better health care to all Americans. Today, the Association is still serving the interest of more than 13,000 minority physicians and their patients, particularly the doctors who serve and the patients who reside in the nation's urban metropolitan communities.

We commend Secretary Bowen for the establishment of the Advisory Committee on Catastrophic Illness and the work they have done in recent months to examine the issues involving expanding access to medical care to the nation's high risk groups (the elderly, disabled, and low-income Americans).

Catastrophic Protection

This issue of catastrophic medical protection, is one of the fundamental problems that many high risk Americans encounter due to the high cost of medical care and inadequate protection provided to these groups in our society. The existing public health financing programs (Medicare, Medicaid, and Public Health Service Programs) and private health insurance programs do not provide catastrophic medical protection.

Today, more than ever, the Medicare and Medicaid programs cover a decreasing percentage of the health care needs of the elderly, disabled, and low-income Americans. The recent efforts by the Reagan Administration and the Congress have lowered government's committment to expand health coverage, eligibility and benefits under these two important federal programs through budget reductions and efforts to make these programs more cost efficient. The result has been that Medicare's out-of-pocket costs in the form of premiums, deductibles and co-insurance expense have risen greatly in the last six years. The Medicaid program has experienced controversial restructuring by many states in order to reduce spending and provide high quality services in recent years. In addition, many states have established new limitations on eligibility, benefits, and coverage of Medicaid financed services. Thus, data from the Current Population Survey (CPS) indicated that the Medicaid program today serves roughly the same percentage of the overall poverty population as in 1980 — less than 40% of those with incomes under the official U. S. poverty line.

The Public Health Service Block Grants programs have been reduced in the form of federal funding and support for many vital public health programs such as community health centers, mental health services and childhood immunization programs.

There are great gaps at the present time in Medicare coverage which we all know. It does not cover eyeglasses, dental care, hearing aids, foot care, extensive nursing home care or in-home care for the chronically ill elderly. Nor does it provide cost effective health promotion and preventive medical care. We have specific concerns about various issues regarding catastrophic medical protection and would like to share them with the Committee.

Black Families

I am grateful for the opportunity to testify on the problems that many Black families encounter - unmanageable financial burdens that cause them to forego needed medical care. These financial burdens arise both when the costs of medical care rise, and when individuals lack insurance and the financial means to withstand greater out-of-pocket costs. Catastrophic health care burdens arise in a variety of ways for Black families in urban America. For families who lack any insurance coverage, even a simple hospitalization can turn into a catastrophic event. Moreover, often time such families may not seek medical care with a primary care physician until the illness become very serious and require hospitalization. This often exacerbates the cost problem because the illness could have been treated when the illness was less acute. Since 1980 the number of Black families without any public or private health insurance has risen steadily to 30 percent of all Black families lack medical insurance. For older Black Americans who have Medicare coverage, an acute illness is also likely to result in a catastrophic burden with high deductible and coinsurance payments.

Black Elderly

It is estimated that 9 percent of the Medicare population are Black Americans. Many of these individuals are living on fixed incomes and cannot afford to pay the increasing out-of-pocket cost mandated under the Medicare program. One of the most critical issues that the Black elderly need for catastrophic protection rests with the problem of long-term care. The long-term care needs of the Black elderly are acute because Medicare currently does not pay for extended long-term care services. Thus, long-term care needs lead almost inevitably to catastrophic expenses because the costs of treatment are enormous and the insurance protection available even to those who could afford it is minimal.

State Catastrophic Health Programs

Only three states (Alaska, Maine and Rhode Island) have maintained catastrophic health programs to help those individuals who find that they have enormous medical expenses and that their existing resources and insurance coverage are inadequate to cover them. The success of these programs, however, has been mixed. State catastrophic programs are not health insurance plans; rather they are structly state funded programs to assist people who exhausted their own resources while paying catastrophic health expenses. The existing state catastrophic insurance programs are not aimed at the indigent population, although some poor and minority persons have obtained access to insurance protection through these state programs. It is also clear that these programs have not been an overwhelming success. In 1984, only 1,251 people were beneficiaries of these programs in the three states where catastrophic programs exist.

Because of the need to limit state expenditures, each state has taken steps to restrict eligibility. Furthermore, most state plans take into consideration only expenses for those services ordered by a physician; they provide no assistance for catastrophic expenses resulting from long-term care or rehabilitation. Based on the limited experiences of these states with catastrophic medical protection, the NMA supports a national program with uniform benefits, eligibility and coverage criteria. Only a national catastrophic program can serve the diverse needs of the American public.

Health Care Savings Accounts

Currently, the Medicare program does not cover a major area that requires catastrophic medical protection - skilled nursing home care. Other than acute care treatments, skilled nursing home care costs must be provided by either the patient, private resources, or Medicare's 100-day benefit plan or if the patient's assets are depleted they can "spend down" and begin coverage under the state government's Medicaid program. As our elderly population grows older, the demand for nursing home care will grow at an even more rapid rate than it is today. Financing this demand for long-term care in future years is a real catastrophic concern.

At present, comprehensive long-term care insurance is not available for the great majority of elderly Americans. There is a real problem for the poor and middle income elderly who need extensive long-term care services. In addition, many elderly cannot afford to purchase private long-term care insurance.

In looking for a solution to this problem, the NMA has examined a new financing program called Health Care Savings Accounts. This proposal would allow individuals to contribute, to a health retirement account equal to the amount of their Medicare payroll tax each year. This would allow employers to contribute to a Health Care Savings Account in lieu of or in conjunction with their employees. Upon retirement, funds invested in a Health Care Savings Account would continue to receive favorable tax treatment. The withdrawals used to pay for health care, either directly or indirectly through the purchase of private health insurance, would be excluded from taxation similar to Individual Retirement Accounts (IRAs). The NMA opposes the use of a Health Care Savings Account mechanism to help finance long-term care for the elderly and disabled populations. We believe that this proposal would not benefit many of the low-income urban minority elderly populations who cannot afford to invest into these tax exempted savings plans. Therefore, we urge the Congress not to adopt this proposal because it would not benefit a vast majority of low-income seniors who live on fixed incomes.

The NMA supports a few short and long-term reforms in the development of a catastrophic medical protection plan to reduce excessive cost sharing for the elderly, poor and disabled Americans. The following describes the programs we would wish the committee to strongly consider.

Short Term Reforms H.R. 65

On 6 January 1987 Congressman Pepper introduced H.R. 65, Medicare Part C: The Catastrophic Health Insurance Act of 1986. This bill would provide for voluntary comprehensive and catastrophic health care coverage to our nation's 31 million Medicare beneficiaries. The NMA supports Congressman Pepper's Bill to offer a Part C under the Medicare program. The Part C would provide senior citizens with comprehensive catastrophic health care coverage currently unavailable under private or public insurance coverage.

The Bill would require the elimination of current co-insurance and deductible requirements under Parts A and B of Medicare. In addition, Part C would provide home and community-based services for the chronically ill; complete skilled nursing facility and intermediate care facility; eye care; hearing care; dental care; and bi-annual preventive physician visits.

Long-Term Catastrophic Reforms

I. Reduce Cost-Sharing Limits

The National Medical Association believes no American should live in fear that a serious illness or accident will mean bankruptcy or a lifetime of debt. Yet today over 80 million Americans are unprotected against devastating medical costs, and millions more have lost the health insurance protection they now have because of unemployment or the death of a working spouse. The NMA supports in principle that a catastrophic medical protection plan is needed to protect every American from the serious financial burden caused by major illness and injury. NMA supports Senator Kennedy's S. 210 that would encourage catastrophic protection for the elderly and disabled Americans. No American family should be required to pay more than $1500 for medical expenses in a single year. Americans who are not covered elsewhere should be able to obtain affordable catastrophic coverage from a special federal program

II. Long-Term Drug Benefits

Catastrophic coverage is needed for the American public when they have incurred $1500 inexpenses for drugs traditionally used on a self-administered basis. Such drugs often comprise a significant portion of a person's out-of-pocket medical expenses. Once the individual meets the $1500 incurred expenses deductible, payment for these drugs would be made until the termination of the annual catastrophic benefit period.

III. Expand Health Promotion and Disease Prevention Benefits

NMA believes that in addition to a limit on out-of-pocket cost for medical expenses, a catastrophic medical protection plan should contain a health promotion - disease prevention benefit package.

The plan should include six preventive benefits:

(1) Maternal and prenatal care

(2) Well-baby clinic services

(3) Childhood immunization

(4) Hypertension screening

(5) Cervical cancer screening

(6) Periodic health examinations

CONCLUSION

In summary, Mr. Chairman, the National Medical Association believes that American health policy needs short and long term catastrophic medical protection reforms to improve the delivery of medical services.

We strongly urge support for the passage of H.R. 65 and S. 210 as a short term solution to excessive cost sharing under the Medicare program.

We believe in the long term a more realistic, more effective and clearly less costly approach is needed to reform both private and public payment arrangements for medical services.

Council on Medical Legislation

HFMA

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STATEMENT OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
TO THE
U.S. SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
APRIL 7, 1987
ON
HEALTHCARE COVERAGE FOR CATASTROPHIC ILLNESS

The Healthcare Financial Management Association (HFMA) enthusiastically endorses more adequate federal financial participation in the catastrophic illness services than are now being provided. However, we caution against the creation of expectations among the public or others about funds that will be available for new and expanded healthcare services when funding of current services has such significant shortfalls. There must be adequate funds and equitable arrangements for paying for catastrophic health services.

Catastrophic illness is a significant national issue. HFMA applauds the attention being brought to this issue. The goals of covering especially difficult and costly cases, meeting long-term care needs, and protecting the uninsured and underinsured are worthy. But there are some significant downside risks for healthcare providers. Added promises to beneficiaries must be accompanied by adequate payments to the providers of the services. The government's past practices of making promises and then changing the payment rules later leaves us very skeptical.

ABOUT HFMA

HFMA is a professional membership association composed of over 25,000 individuals in 75 chapters who share an interest in financial management of hospitals and other healthcare institutions. HFMA has long been involved in the development of appropriate methodologies for paying for healthcare services. In May 1982, HFMA issued its recommendation for prospective price setting methodologies. In October 1985, we issued a statement dealing with the "Definition of and Payment for Uncompensated Services" (copy attached). In May 1986 each of our 75 chapters was asked to study the issues raised by the Secretary's Private/Public Sector Advisory Committee on Catastrophic Illness. This statement reports to you the concerns expressed by HFMA members based on their years of experience with various arrangements for paying for healthcare services.

CURRENT PROVISIONS FOR ESPECIALLY DIFFICULT AND COSTLY CASES

Especially difficult and costly cases are currently being served. These services may be covered by Medicare DRG payments, or the patient may be responsible for uncovered services, deductibles, and coinsurance.

Medicare Payments

When Medicare beneficiaries require acute care services of catastrophic proportions, these services are provided. Reportedly, only 2 percent of Medicare beneficiaries exhaust their benefits, which is rather clear evidence that catastrophic services that are covered by Medicare are being provided.

If catastrophic service is covered by Medicare, payment probably involves the Medicare "outlier" provisions -- extra payments for extraordinary cases that are especially costly or lengthy. These additional payments are supposed to be 60 percent of actual costs -- a very deficient payment for the toughest cases. In actual practice, outlier payments bear little relationship to the cost of services provided. This is a seriously deficient feature of the current PPS system.

Congress has already provided the outlier mechanism for meeting some catastrophic acute care needs of Medicare beneficiaries. Congress said to pay between 5 percent and 6 percent of all payments for outliers but HCFA is distorting this provision by paying far less than Congress provided. Even though HFMA, the Prospective Payment Assessment Commission (ProPAC), and others have requested data about actual outlier payments, the Health Care Financing Administration (HCFA) has not released actual outlier payment data on a timely basis. The experience with this arrangement makes healthcare providers skeptical about equitable administration of any new, federally administered catastrophic program.

The outlier payment arrangement should be changed, regardless of new catastrophic coverage, to:

- Make payments fully in accord with congressional direction;
- Require regular reporting of actual payments for outlier cases;
- Raise the ratio of cost paid for outlier cases; and
- Remove the linkage between day and cost outliers.

Uncovered Services

Many other services of a catastrophic nature are also being provided to Medicare beneficiaries in the form of post-acute care, extended care, and noninpatient care for which Medicare coverage is unavailable or, in many cases, inadequate. Much of this service is uncompensated to the provider and no governmental program shares in these costs. In addition, services are provided to many people who are uninsured or underinsured due to unemployment, failure of employers to make adequate insurance available, and personal decisions to forgo or limit insurance coverage.

Medicare, as the largest payer of healthcare services, and other federal or state programs makes no contribution to the uncompensated portion of these services. The government is shifting its financial responsibility for these services to others. It is time for Medicare to meet its proportionate share of these costs.

Deductibles and Coinsurance

Deductible and coinsurance provisions make some of the payment for currently provided services the patient's responsibility. Medicare beneficiaries may insure this obligation with Medigap insurance, but this coverage would be replaced by the extended Medicare benefits envisioned under some catastrophic proposals being discussed. Patients who currently receive catastrophic services that Medicare or Medigap does not cover may pay out of their own pocket, but it is likely that many such cases are uncompensated and are added to providers' charity load.

The current deductible and coinsurance payments are not related to cost of service in any way. Thus, if payment for catastrophic service simply pays what patients might pay under the current deductible and coinsurance provisions, the providers will not get payments that are even remotely related to cost.

If beneficiaries are required to pay a significant amount (Secretary Bowen's plan specifies $2,000 a year) much of this will result in bad debts. While Medicare currently pays for bad debts, HHS Inspector General says this payment is inconsistent with prospective rates -- a fallacious argument as long as PPS rates are a roll forward of rates from an era when this payment was part of the formula. Deductible and coinsurance provisions must not add to the burden of uncompensated services.

UNCOMPENSATED SERVICES

A special HFMA task force has studied uncompensated services. It reached the indisputable conclusion that "if institutional healthcare providers are to remain financially viable, there is no alternative but for payers to pay for uncompensated services."* Providers cannot provide services if payment is inadequate. Thus, the responsibility for financing catastrophic services must not be shifted to healthcare providers.

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*HFMA's statement concerning "Definition of and Payment for Uncompensated Services and Special Problems of a Disproportionate Share" is attached.

Provision of uncompensated services is a real and legitimate business expense and all customers should share in this cost. Food given to the needy and credit losses incurred by a grocery store are an integral part of the prices paid by all customers of that grocery store. The same is true in any business. Similarly, Medicare must share in the financing of uncompensated services provided to non-Medicare patients. A recent HFMA survey shows that 5.5 percent of revenue (after reduction for contractual allowances) is uncompensated. This is a very real cost that Medicare should share.

Recent legislation provides supplemental Medicare payments for the higher cost of serving Medicare patients by providers with a disproportionate share of uncompensated services. This provision recognizes the special characteristics of patients served by these providers but does not address the uncompensated services problem. The current procedure of indirect taxation through payment shortfall in Medicare and other government sponsored programs is not an appropriate model for meeting catastrophic illness requirements. It is essential to recognize that services that are provided must be paid for by someone and Medicare must pay its share.

INCREASED DEMAND

A government promise to cover the most difficult circumstances that require acute care services, to cover long-term care services, and to cover services to the uninsured or underinsured will doubtless foster provision of even more of these services than in the past. This is a desirable result for beneficiaries, of course, but a risk for both the government and providers. We only need recall the results of coverage of renal dialysis services to recognize that increases in demand and huge increases in cost will result. The ESRD program is clearly beneficial. Lives have been improved, extended, and saved. But the costs have been much greater than expected. If more catastrophic services are to be provided, the payment arrangements for these cases is a critical consideration. The government must recognize and be willing to accept the financial consequences of its public policy decisions. One of our chapter groups raised the pertinent caution that "the program will promise much and pay for little."

Diminished insurance coverage of patients' financial responsibilities, any change in arrangements for Medicare payment of bad debts, and the inadequate payments that result from the current "outlier" methodology all raise questions about the adequacy of payment for catastrophic services. These are concerns even at current levels of service and even more serious concerns if more catastrophic services are called for.

RULES CONCERNS

Providers also have no difficulty recalling the many ways that the government changes the payment rules after the game has begun. This happened repeatedly in the Medicare cost-based payment era and has continued with new creativity under PPS. The original goal of PPS was to limit the rate of increase in federal healthcare expenditures. Providers were offered the opportunity to profit through fulfilling that goal. The federal government has not only controlled expenditures, but has saved tremendous amounts in comparison to what would have been spent under the former system. But rigid budget targets resulted in changed rules and frozen rates; denying providers the promised rewards that were part of the original plan. In fact, a recent HFMA survey shows that hospitals expect to loose money (1.1%) next year from serving Medicare patients.

Revenue from new catastrophic insurance premiums could go a long way toward solving the federal deficit if the government devises ways to promise the services but avoid paying for them. The government will not, of course, simply receive and keep the revenue while telling the healthcare industry to provide increased services with no increase in payments. There are alternatives for changing the rules to achieve the same result, however. Current consideration of "rebasing" is an example. This is just a euphemism for lowering the rates hospitals are entitled to. Another option is for the government to freeze rates for current services, pay something for additional services, and say that total payments have increased.

The "case-mix shuffle" can also be used to avoid paying for expanded catastrophic coverage. (The government has reduced PPS rates to offset much of the effect of increases in case mix, the measure of the relative complexity of cases served. While everyone agrees that rates should not increase because of changes in case coding practices, the industry contends that cases served are really more complex and has challenged the government to do a study to measure the change in coding practices, but the government has refused.) As more catastrophic cases are served, the government can contend that the increased complexity apparent in higher case-mix amounts is just the result of a change in coding practices and deny higher payment for these more complex cases. The manipulation of payment by changing case mix is inappropriate.

Failure to recognize increased severity adds to our concern about the inequity of case-mix arrangements. Patients are being kept alive that would have died and costly new technologies are more broadly available. Thus the high cost of serving catastrophic cases is not adequately measured by the current case weight system. Changes in severity of illness must be recognized.

Payment rules must honor the original commitments, must not offset real case-mix change by rebasing and case-mix adjustments, and must recognize severity changes.

CONCLUSION

Attention to catastrophic illness issues is timely. We enthusiastically endorse more adequate federal financial participation in the catastrophic illness services that are now being provided. We support better access to catastrophic service for as many people as our nation's economy allows. We also support a financial relationship that is equitable and protects the interests of all people.

RRK/mlh

4/7/87

TESTIMONY OF THE

AMERICAN ACADEMY OF FAMILY PHYSICIANS

ON

CATASTROPHIC HEALTH INSURANCE

The American Academy of Family Physicians is the national medical specialty organization representing more than 59,000 family physicians, medical students and family practice residents.

We are pleased to have the opportunity to address a problem of mutual concern to members of this committee and to family physicians throughout the country--the need for access to catastrophic health coverage for all Americans. We commend the members of this committee for the thorough review that you are giving this subject.

At the outset, we do want to point out that catastrophic initiatives are of limited good in achieving increased access to health care, because they are oriented toward coverage of hospital care, and not preventive or maintenance care, or long term care. However, the Academy views the effort in Congress to address catastrophic coverage as a positive step toward the eventual assurance of access to appropriate health care for all Americans.

Family physicians see, first hand, the need for protection from catastrophic health care costs. We share with our patients and their families the fear of financial devastation that can result from serious illness or injury. In our offices we are caring for patients who require an increased intensity of services because they are discharged from the hospital earlier--and sicker. Many of these services are not adequately covered by Medicare. We struggle with the dilemma of our elderly patients whose families are not able to care for them at home, but who cannot afford nursing home care. We see families forced into poverty by health care expenses before meeting Medicaid eligibility criteria for nursing home care. And although we may not see them, we know there are many patients who opt to go without needed care because of gaps in Medicare coverage.

Catastrophic medical events pose a financial threat to Americans of all ages and therefore the need for catastrophic coverage is not limited to acute care for the Medicare population. Rather, the need encompasses the acute care expenses of the elderly, long term care expenses, and catastrophic coverage of the general population. The American Academy of Family Physicians has considered the issue of catastrophic coverage from this broad perspective and has considered various options to address each of these areas of need. We look forward to working with you to address catastrophic coverage in a comprehensive fashion.

Current Medicare Acute Care Coverage

The financial liability of the Medicare beneficiary for acute care can become quite substantial under the current system as there is no upper limit on the out of pocket expenses the elderly may pay for services.

Currently under Medicare Part A the beneficiary must pay $520 for the first day of hospitalization. The amount serves as the deductible. Then for days 2-60 of a single spell of illness Medicare covers the inpatient care without charging the beneficiary. However, the beneficiary liability increases to $130 per day for days 61-90, and for days over 90 (which are taken from the 60 days of lifetime reserve) the beneficiary copayment is $260 per day.

Under Part B the annual deductible per beneficiary is $75.00. Part B covers 80% of what Medicare determines is a reasonable charge for physicians services, with the beneficiary liable for the 20% copayment, plus any additional amount charged by the physicians. Neither routine physician services nor outpatient prescription drugs are covered by Medicare.

Proposals For Catastrophic Coverage of Acute Care

Proposals have been introduced in Congress which would go a long way toward limiting out of pocket medical expenses. We commend the Members of Congress who have thoughtfully contributed to the current debate on catastrophic health care insurance. Most discussed are proposals based on the plan developed by HHS Secretary Otis Bowen, S.592, S.754 and H.R. 1245, and proposals introduced by Representatives Stark and Gradison, H.R. 1280 and H.R. 1281. The AAFP supports provisions in these proposals to eliminate coinsurance for hospital stays and provide unlimited hospital days after the required deductible is met. Another good feature in both would improve the skilled nursing home benefit by reducing beneficiaries' coinsurance liability.

The Stark-Gradison approach provides a slightly more comprehensive total benefit package than the Bowen proposals and is also more costly. Other plans are being discussed with more benefits which also add to the cost of the program. The feasibility, administrative simplicity and wide support of the Bowen plan, however, are extremely attractive features. We believe these are important features which make it possible to enact this proposal as soon as possible.

Financing of Acute Coverage

While the need for catastrophic health care coverage is clear, the strategy for providing access to such coverage is not. The ability to finance a catastrophic program in fact defines the scope of the coverage that can be provided. The American Academy of Family Physicians encourages Congress to balance fiscal responsibility with compassion for the elderly in evaluating proposals for catastrophic coverage.

Catastrophic coverage of acute care expenses of the elderly should be accomplished through restructuring of the Medicare program. Such a restructuring should limit the financial liability of the beneficiary for acute care, and cover an unlimited number of days of acute hospital care. A responsible approach to providing this type of Medicare coverage would be to have Medicare beneficiaries share the catastrophic risk through payment of an actuarily sound additional premium. As outlined in S.592, this approach would provide a $2000 annual limit for out of pocket expenses for Medicare covered services, a limit which would be affordable for nearly all beneficiaries. While a lower out of pocket limit than $2000 annually may be desirable,

we are concerned that the additional premium that would be required to finance the catastrophic program would prove too costly to low income elderly. In this event subsidized purchase of the catastrophic policy for low income individuals, perhaps through a voucher or a tax credit, might be necessary.
Other proposals, H.R. 1280 and H.R. 1281, would finance the catastrophic benefit by taxing a portion of the benefit's actuarial value. Approximately 35% of the elderly with the highest incomes would be taxed under this strategy. It would avoid imposing additional financial burdens on low income elderly and additional taxes on current workers. However, should program costs increase more rapidly than projected or as additional benefits are added, the increased cost to middle and higher income beneficiaries could become a financial strain.

CATASTROPHIC COVERAGE OF CHRONIC OR LONG TERM CARE

Protecting the population from the costs of long term care for the chronically ill also should be addressed by Congress. According to the AARP, nursing home stays account for over 80% of the expenses incurred by older people spending over $2000 per year out of pocket for health care. With Medicare and private insurance paying an estimated 3% of nursing home costs, Medicaid is the only alternative available to many of the nation's elderly. Life savings and assets are depleted to pay for nursing home care before Medicaid eligibility requirements are met. Spouses are left impoverished in order that their partners receive the care that they need. Family physicians are keenly aware of the impact of long term care expenses on their patients, their spouses and their families.

Solutions for providing protection from the catastrophic expenses of long term care are more difficult to develop than other components of catastrophic health coverage. The AAFP believes that the combined efforts of the government and the private sector are needed to address this problem. Steps taken immediately to protect some of the population at risk may stimulate other initiatives which will cover a broader population.

In the Congressional Record of March 17, Senator Chafee notes that "approximately one-half of all Medicare recipients in nursing homes were not initially poor, but spent their income and resources on long term care before becoming eligible for Medicaid." The AAFP believes that a variety of strategies for addressing long term care should be considered. This organization supports the following Bowen report recommendations:

*the federal government work with the private sector to educate the public about the risks, costs, and financing options available for long term care, as well as the limitation of coverage for such services under Medicare and Medigap supplemental insurance.

*that the federal government encourage personal savings for long term care through a tax favored Individual Medical Account (IMA) combined with insurance, and amend Individual Retirement Accounts (IRA) provisions to permit tax-free withdrawal of funds for any long term care expense.

*encouraging development of the private market for long term care insurance by establishing a refundable tax credit for long term care insurance premiums, providing favorable tax treatment for long term care insurance reserves and removing barriers to prefunding long term care benefits provided by employers to retirees.

*offering employee-paid long term care group insurance as an option under the Federal Employees Health Benefit Program.

Other options for financing long term care which should be explored include state home equity conversion programs, which would provide additional liquidity for house-rich/cash-poor persons to pay for long term care without being forced to sell their homes, and capitated delivery systems, such as HMOs, to spread the risk.

The Academy believes that Congress must consider means of addressing the costs of long term care in its discussions of catastrophic coverage, costs which are the major concern of the population. We believe the above options, which have been endorsed by the American Academy of Family Physicians should be given serious consideration.

Medigap

An estimated 70 percent of the Medicare population purchases Medigap policies to supplement what Medicare pays. The elderly often don't understand what the gaps in Medicare coverage really are, and purchase plans which are not adequate or which do not cover preexisting conditions. Some purchase multiple plans out of the fear of financial ruin that a long illness can bring only to find that the plans do not cover their medical care. The Academy would recommend that the federal government mount an intensive information campaign to improve public understanding of Medicare and Medigap coverage limitations. This is particularly important in the area of long term care. Much of the public is unaware that Medicare does not cover long term care and that most Medigap policies are structured to address gaps in acute care coverage, not long term care needs.

We are concerned that if Congress enacts an acute care catastrophic benefit the public must be fully informed of the limitations of Medicare coverage which will still exist. Beneficiaries will continue to assume financial risk for uncovered service, various deductibles and coinsurance.

Conclusion

This year there is the momentum in Congress to enact legislation to fill some of the gaps in Medicare coverage. The American Academy of Family Physicians urges Congress to seize the opportunity to take this important first step toward the provision of comprehensive catastrophic health coverage for the American public.

Thank you for the opportunity to appear before you today. I would be pleased to answer your questions.

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STATEMENT
OF THE
AMERICAN HOSPITAL ASSOCIATION
TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
OF THE
UNITED STATES SENATE
ON
CATASTROPHIC COVERAGE

April 20, 1987

SUMMARY

Fashioning any comprehensive solution to the problem of catastrophic illness will require addressing three gaps in health insurance coverage: (1) inadequate Medicare coverage of catastrophic acute care costs, (2) even more inadequate public and private coverage of long-term care costs, and (3) the presence of large numbers of uninsured and underinsured in the non-Medicare population. AHA's recommendations fall into these three areas.

To address the issue of acute catastrophic illness for Medicare beneficiaries, AHA suggests:

- Elimination of existing limits on the coverage of acute inpatient hospital care;

- Expansion of coverage for home health and skilled nursing services used in lieu of more expensive alternatives, and extending coverage to prescription pharmaceuticals;

- Replacement of the confusing and often counterproductive cost sharing requirements with an annual deductible and uniform coinsurance levels for all Parts A and B covered services combined, subject to an annual out-of-pocket expenditures limit that is tied to a beneficiary's income;

- Institution of a Medicare premium to fund the expanded coverage that would be paid by all beneficiaries, not just those enrolled in Part B; and

- Creation of a program of supplemental coverage for beneficiaries eligible for Supplemental Security Income that would pay the new Medicare premium thereby effectively reducing required copayment to zero, and possibly making a supplemental policy available to non-SSI beneficiaries at an actuarially sound premium.

To address the most common cause of catastrophic medical expenses among the aged--long-term care for chronic illnesses, including those involving psychiatric diagnoses and requiring rehabilitation treatment--AHA recommends:

- Support for the development of private-sector alternatives for financing long-term care through tax incentives for individuals purchasing long-term care insurance and for research into how such insurance can be structured, as well as public education as to the costs and likelihood of catastrophic illness leading to the need for long-term care;

- Separation of the long-term care component of Medicaid from its other components to encourage the development of alternative methods of both financing and delivering long-term care to the elderly who need public assistance; and

- Substitution with a system of federal and state subsidized loans through which a family could "borrow" against a beneficiary's estate to meet the cost of long-term care to protect the ability of patients to return to their homes and to enable dependents of individuals needing long-term care to maintain their independence and dignity.

Finally, concern over the problem of catastrophic illness among the Medicare population should not divert attention from the significant problem of medical indigence in the non-Medicare population. For them, the major cause of catastrophic expense is acute medical care. To address the catastrophic needs of the non-Medicare population, AHA recommends:

- Implementation of public- and private-sector initiatives to reduce the number of uninsured and expand private catastrophic coverage;

- Strengthening of public programs to provide coverage for those individuals unable to purchase private health insurance; and

- Provision of information to the underinsured, through insurers and employers, on the cost and potential value of catastrophic coverage.

The American Hospital Association commends the committee for its willingness to tackle the multifaceted problem of providing desperately needed relief for Americans from the fear of catastrophic illness and expense. We pledge our support and cooperation in your work to address this issue.

INTRODUCTION

The issue of catastrophic coverage is of great concern to the American Hospital Association's 5,600 member health care institutions. Over the past several years, the AHA has examined a number of alternatives for improving the Medicare benefit package, for making it more comprehensible to Medicare beneficiaries, and for ensuring the long-term fiscal soundness of the program. The AHA also has examined public- and private-sector alternatives for addressing the needs of the non-Medicare population who are medically indigent.

Last December, the AHA had the opportunity to present to another committee of Congress our recommendations for a comprehensive approach to catastrophic coverage, addressing needs of the elderly and non-elderly for acute and long-term care. The increased level of debate and interest that has occurred since then is heartening. Several bills have been introduced that address certain aspects of the catastrophic illness problem, including the Administration's proposal, S.592, introduced in the Senate by Senator Dole. You are to be commended for your willingness to address the multifaceted problem of providing desperately needed relief for Americans from the fear of catastrophic illness and expense.

We would like to take this opportunity to review the scope of the catastrophic illness problem and our recommendations for a comprehensive approach to its resolution, concluding with a few comments on the Administration's proposal.

DIMENSIONS OF CATASTROPHIC ILLNESS

Each year, thousands of families face financial ruin because one of their members incurs health care expenses that are not covered by insurance and are beyond the family's ability to pay. When this happens, a serious illness --which can be a personal catastrophe--becomes a financial catastrophe for the entire family. Most Americans are protected against the cost of acute medical care through either private insurance, Medicare, or Medicaid. But, 37 million Americans face financial catastrophe from serious illness because they lack any form of insurance. An estimated 20 million of the non-Medicare insured population also may be at risk for catastrophic acute care because of limitations on private insurance coverage. Even in the Medicare population, a substantial amount of acute care must be paid out of pocket because of limitations on Medicare coverage.

Catastrophic expenses result from three gaps in health insurance coverage: inadequate Medicare coverage of catastrophic acute care costs; even more inadequate public and private coverage of long-term care costs; and the presence of large numbers of uninsured and underinsured in the non-Medicare population.

As currently structured, Medicare does not provide catastrophic coverage, even for acute care. Acute inpatient hospital care can cause significant out-of-pocket expenditures for a small percentage of beneficiaries. For example, a patient staying in the hospital 60 days incurs an inpatient deductible of $520, plus 20 percent of any physician charges. The copayment totals $4,200 after 90 days and $18,942 after 150 days. This does not happen very often: in any given year only 20-25 percent of Medicare beneficiaries require inpatient care, and less than 1 percent of those hospitalized in an acute general hospital stay more than 60 days. In 1984, beneficiaries incurred about $4.8 billion dollars in first-day deductibles--accounting for 98 percent of all copayments and deductibles for general hospital acute care admissions. When Part A and Part B services are considered, it has been estimated that about 8 percent of enrollees owed coinsurance and deductibles in excess $1,024 in 1984. It should be noted, however, that new delivery patterns emphasizing outpatient care are creating new gaps between patient expenses and Medicare coverage and, therefore, new patterns of catastrophic expense.

Although the incidence of acute catastrophic care expense may be small, most Medicare beneficiaries may perceive themselves to be "at risk" because catastrophic expenditures are difficult to predict, and Medicare coverage rules are hard to understand. Most Medicare beneficiaries purchase supplemental or "wrap-around" coverage, perhaps perceiving it as protection against catastrophic acute care expenses or possibly as protection against long-term care costs as well. But, "wrap-around" coverage benefits are limited to Medicare-covered services, which means that even with "wrap-around" policies, most Medicare beneficiaries still run the risk of incurring catastrophic out-of-pocket acute care expenses and have almost no protection against long-term care costs.

Outpatient pharmaceuticals are another significant and growing source of out-of-pocket expenditures for the elderly, with only about 20 percent of such costs covered by any form of insurance. As more care shifts to non-institutional settings where Medicare does not cover prescription drugs, out-of-pocket expenses are increasing. Many beneficiaries find themselves choosing between spending limited resources on needed drugs or on the basic necessities of food and shelter.

Another obvious gap in the Medicare program is catastrophic coverage for the treatment of mental illness. Although approximately one-fifth of the Medicare population should have such treatment (the American Psychiatric Association estimates), those with mental health problems are subject to a 50/50 copayment, and Medicare will pay no more than $250 for outpatient care of mental or emotional disorders. Those with acute mental illnesses--episodic or chronic--require services on a recurrent or continuing basis.

Gaps in insurance coverage also exist for patients needing medical rehabilitation, whether it is the Medicare beneficiary recovering from a stroke or a young accident victim requiring extensive occupational and physical therapy.

Among Medicare beneficiaries, the leading cause of catastrophic expense is long-term care associated with chronic illness. Medicare provides little coverage for institutional long-term care, consistent with its focus on covering the cost of acute medical episodes. More than 90 percent of expenditures for long-term care now come from two sources: out-of-pocket expenditures and Medicaid. Out-of-pocket expenditures by consumers account for about 45 percent of all long-term care expenditures. Among elderly families spending more than $2,000 in a year for medical care, 81.2 percent of the expenses are for nursing home care, compared with only 10 percent for hospital care and 5.9 percent for physician care. As a result, almost half of the 75-year-olds who enter private nursing homes are bankrupt in 13 weeks, and more than 70 percent exhaust their resources after a year. Once these catastrophic expenditures have been made, the elderly can obtain catastrophic coverage from Medicaid, but by that time the illness will have impoverished any non-institutionalized spouse or dependent, and thereby pushed more people into a state of public dependency.

This use of Medicaid as the payer of last resort for long-term care has absorbed a large and increasing proportion of Medicaid funds and put considerable pressure on funds available to support the non-Medicare poverty population. Currently, about three-fourths of all Medicaid expenditures are used to pay long-term care costs and other expenses generated by Medicare enrollees, leaving about one-fourth for the growing number of non-elderly, non-disabled poor. This conversion of Medicaid into a supplemental policy for Medicare enrollees exacerbates the third catastrophic care problem: the presence of a large and growing number of uninsured and underinsured non-elderly. For those without insurance, any significant illness is generally catastrophic, and the number of uninsured is growing. By 1985, 37 million people lacked insurance, one-third of them living below the poverty level and another third below double the poverty level. This large and growing number of uninsured results from two trends: an increase in the number of people below the federal poverty level, and a simultaneous decrease in the number of people covered by Medicaid. By 1983, Medicaid covered less than 40 percent of the poor, compared with 65 percent in 1976. For the uninsured, the most frequent cause of catastrophic illness is acute care, and even moderate expenses can be catastrophic.

The absence of insurance coverage for non-catastrophic acute care may actually increase the likelihood of catastrophic illness. For example, many studies have shown that lack of prenatal care, a frequent occurrence among the uninsured, results in high-risk births and often very high neonatal intensive care costs. In addition, of those who are insured, a significant minority--especially those with individual rather than group coverage--still run a significant risk of incurring medical bills they cannot pay, and therefore are "underinsured" for catastrophic care. One study found that about one-fourth of the non-elderly population--more than 57 million people in 1985--is either uninsured or underinsured. Although much of the discussion regarding catastrophic health insurance has focused on the elderly population, children and their families also suffer from the effects of catastrophic illness. Although Medicaid covers poor children, benefits vary widely from state to state. It is estimated that 12 million children under the age of 18 are uninsured. And even for families with insurance, a traumatic childhood illness or a serious chronic disease or disorder could result in financial catastrophe for the family, either through increased out-of-pocket expenses or wages lost because of time spent with an ill child.

In a sense, uncompensated care costs represent a second stage of catastrophic care costs, after a person or family can no longer pay out-of-pocket for uncovered care. In 1985, uncompensated care (charity care and bad debt) provided by hospitals to those unable to pay cost hospitals--and, indirectly, other hospital patients--$7.4 billion. This was more than double the cost in 1980. Given the current conscientious debt-collection efforts made by hospitals, this $7.4 billion represents costs that patients could not pay, i.e., clearly catastrophic costs.

In short, while discussions of the catastrophic care problem frequently focus on the dramatic, relatively rare, acute care expenses of the elderly, the catastrophic care problem is much broader and much deeper, extending to both young and old, uninsured and insured.

TOWARD A COMPREHENSIVE SOLUTION

Any comprehensive solution to the problem of catastrophic illness must address the three gaps in health insurance coverage: (1) inadequate Medicare coverage of catastrophic acute care costs, (2) even more inadequate public and private coverage of long term care costs, and (3) the presence of large numbers of uninsured and underinsured in the non-Medicare population. The AHA's recommendations fall into these three areas.

Medicare Catastrophic Acute Care

For Medicare beneficiaries, major issues include the fear of future insolvency and collapse of the program, and an acute care benefit that covers less and less of their expenses.

Long-term Solvency of Medicare. Although improved in recent years, the financial outlook of the Medicare program remains cloudy. The declining ratio of workers to beneficiaries will contribute to long-term financial instability in the Medicare program and may place a severe burden on future generations of workers. Consequently, some have suggested the imposition of a means test to limit the size of the eligible population and to reduce future expenditures. Such proposals should be rejected. Universal coverage creates a strong base of political support for the program and spreads risk across the entire population. Also, many of the non-poor elderly and disabled would have major difficulties obtaining adequate private coverage, and most non-poor elderly would quickly become medically indigent if they suffered a catastrophic illness.

Medicare should continue to provide universal coverage for the elderly and disabled. Eligibility should not be tied to beneficiary income, but should be tied to the age of eligibility for Social Security benefits. Basic Medicare benefits should continue to be funded on a pay-as-you-go basis. To address the actuarial problems anticipated as a result of the changing demographic structure of the United States, and to fund acute care catastrophic coverage, Medicare should institute a premium, which should be included in out-of-pocket costs when comparing individual expenditures to an annual out-of-pocket limit. Through Medicaid, Medicare should pay the Medicare premium and provide supplemental coverage of required coinsurance for Medicare beneficiaries receiving or eligible for supplemental security income (SSI).

Restructuring the Benefit. The original Medicare benefit was structured around the belief that most acute care occurred in inpatient hospital settings. This is no longer entirely true. Services that are not covered at all by Medicare, such as prescription drugs provided to non-inpatients, have become an increasingly important part of medical expenditures of the elderly. The principal barrier to coverage of prescription pharmaceuticals has been the fear of substantial utilization and cost increases resulting from coverage for beneficiaries who use small amounts of services or for whom the costs of such services are a small percentage of income. These problems can be reduced by expanding the set of covered services to include prescription pharmaceuticals, but limiting that coverage with an annual deductible and copayments until an annual out-of-pocket limit is reached.

A more significant problem results from the increased reliance on alternatives to inpatient hospital care. Expenditures for outpatient services have risen as care has moved from the inpatient setting to the outpatient setting--for example, in the substitution of outpatient for inpatient surgery. Out-of-pocket expenditures have been increasing as a result because outpatient services more often carry copayment requirements.

A second source of increased out-of-pocket expenditures has been for covered skilled nursing facility (SNF) care. The current copayment level virtually eliminates the SNF benefit for all but the first 20 days. Medicare limits on the average daily routine cost allowed for SNF care, which vary by area and type of facility, range from $60 to $90. Because the current copayment is a set $65, Medicare only pays from zero to about 25 percent of the cost for days 2l through 100.

A third source of increased out-of-pocket expenditures is skilled nursing and home health services for which Medicare coverage is denied. Medicare beneficiaries are often caught up in the patent absurdity of being told they are not sick enough to warrant admission to a hospital, but they are too sick to be treated at home, and they cannot be treated in a SNF because they have not met the three-day prior hospitalization rule. Medicare administrators have used the absence of clearly defined coverage criteria to apply increasingly stringent medical criteria to skilled nursing and home health claims, resulting not only in the denial of coverage but also increasing reluctance on the part of some providers to accept Medicare patients.

The most pressing need is to require that medical review criteria used by fiscal intermediaries be written and made available to providers and beneficiaries to promote understanding of the benefit and better assessments of the appropriateness of claims denials for home care and skilled nursing care. Making some sense of coverage criteria for these services also should focus on a sorting out of where beneficiaries should be cared for when they have an acute episode of illness, and on providing the flexibility to use the appropriate level service without artificial barriers. In the course of doing so, it will be important to establish more appropriate conditions under which the services will be covered, including: relaxation of the "home-bound" and "intermittent care" requirements for covered home health care; elimination, in whole or in part, of the three-day prior hospitalization requirement for receipt of SNF care; and elimination of arbitrary barriers to the provision of and payment for needed skilled subacute services by qualified hospitals when extended care services are needed but appropriate placement is unavailable.

Even with Medicare's focus on acute inpatient care, some beneficiaries experience catastrophic expenses for their in-hospital care. Beneficiaries who exhaust the "basic" inpatient benefit of 60 days can rapidly incur copayments amounting to several thousand dollars, and each year a small, but significant, number of beneficiaries exhaust their "lifetime reserve" coverage of acute inpatient services. For these individuals, and for those beneficiaries who experience multiple hospital admissions in a single year, out-of-pocket expenditures can be substantial.

In addition, beneficiaries often have trouble understanding when their care will be covered. The use of "benefit periods" or "spells of illness" to determine if an inpatient stay is covered is confusing. Eliminating the limits on inpatient coverage would both provide coverage of catastrophic hospital stays and would make the Medicare benefit less confusing to beneficiaries. Further, the pattern of copayment varies by type of service, leaving beneficiaries uncertain as to their out-of-pocket obligations. An annual deductible for all covered services, combined with uniform copayment up to a maximum out-of-pocket limit keyed to income, would establish positive consumer incentives and protect all beneficiaries against catastrophic costs. An SSI supplemental package would protect access for low-income beneficiaries.

To address catastrophic acute care expenses resulting from inadequacies in the current Medicare benefit package, several changes should be made:

- Unlimited inpatient hospital care should be covered by eliminating all current limits;

- Coverage should be extended to prescription pharmaceuticals; and

- The restrictions on coverage of home health and skilled nursing services should be revised to permit beneficiaries to make use of less expensive alternatives to inpatient acute or long-term care, e.g., by relaxing the intermittent care and home-bound requirements for home health services and the three-day prior hospitalization requirement for SNF services.

The current system of copayment should be replaced by requirements that establish positive consumer incentives, that are sensitive to differences in beneficiary income, and that are more understandable to beneficiaries:

- Combined Part A and Part B expenditures for covered services should exceed an annual deductible before Medicare begins to provide coverage;

- After the annual deductible has been satisfied, a uniform percentage copayment should be applied to all covered services, subject to an annual out-of-pocket limit;

- Once the annual out-of-pocket limit is reached, no additional copayment should be required; and

- The annual out-of-pocket limit should vary with beneficiary income.

Supplemental insurance for required copayments and non-covered services should continue to be available through private insurers. As an alternative to private supplemental insurance, Medicare could offer a voluntary supplemental coverage option that would reduce required annual out-of-pocket expenditures. This coverage could be paid for through a premium equal to the actuarial value of the coverage, and would not be subsidized by tax appropriations to avoid preempting the private insurance market.

Also, the creation of tax incentives to allow Individual Medical Accounts (IMAs) should be considered as a means of encouraging Medicare beneficiaries to accumulate sufficient savings for future medical care costs, including the purchase of supplemental coverage, payment of the Medicare premium and copayment amounts, purchase of private long-term care insurance, or payment for long-term care. While IMAs cannot serve as a cornerstone for financing Medicare, they may reduce the future need to use general revenues or payroll taxes to fund care, particularly long-term care.

Offering beneficiaries the option of enrolling in qualified private health plans, which combine the financing and delivery of care and are paid on a capitation basis, also has potential as a means of providing catastrophic coverage at lower total costs to the program and beneficiaries. The expansion of these alternatives may be limited in the short term by the absence of actuarially sound methods of computing premiums or voucher amounts for individuals and small groups. Medicare should continue research and demonstration activities needed to develop and test methods of implementing a capitation option more widely.

Long-Term Care for the Medicare Population

Long-term care is the leading cause of catastrophic medical expenses among the elderly. Out-of-pocket expenditures by patients and their families are the most important source of financing for long-term care. Medicare covers only limited, post-acute skilled nursing care, while Medicaid covers long-term care at the skilled nursing, intermediate, and custodial levels. To qualify for Medicaid coverage, it is necessary to spend down savings and investments, including investments in a family home. Thus, to qualify for public assistance, it is necessary to incur catastrophic expenses.

The financing of long-term care (including skilled nursing facility, intermediate care facility, home care, and custodial "nursing home" care) has been, and will continue to be, a shared responsibility of individuals, the private sector, and state and federal government. The goals of public policy should be: to encourage individuals to make provision for long-term care needs to the extent permitted by their income; to provide access to needed long-term care when individual resources are inadequate; and to establish a more humane alternative to spend-down requirements. To attain these goals, we believe that:

- The development of private sector alternatives for financing long-term care should be encouraged through tax incentives and demonstration projects supported by both the public and private sector. IMAs might be structured as a type of long-term care insurance. These initiatives should include efforts to increase understanding among the elderly and non-elderly of the need for and cost of long-term care;

- For the population dependent upon public assistance, public programs should stress keeping patients out of institutional settings, when appropriate, and should encourage innovation in the delivery of care to the chronically ill. The restructuring of Medicaid and creation of a distinct program of long-term care coverage for low-income Medicare beneficiaries would encourage such innovation; and

- To protect the dependents of chronically ill individuals, and to reduce the risk of long-term dependency by those needing limited amounts of long-term care, a federal and state program of loans could be established through which a family could "borrow" against a beneficiary's estate to meet the cost of long-term care (including skilled nursing, intermediate, and custodial care) for an institutionalized family member. In the case of couples, the non-institutionalized spouse would retain the use of the assets until his or her death.

In the long term, it appears that the system of financing long-term care will continue to involve both the public and private sectors, although current public and private arrangements leave room for substantial improvement. More work is needed to develop innovative approaches in both the public and private sector, and to identify how best to meet the varying needs of different populations. Proposals such as the IMA, if combined with long-term care insurance, offer a potential means of encouraging the development of a more rational private system for financing some long-term care. Proposals to restructure Medicaid offer a potential means of making better use of public funds to care for those unable to finance their own care. And the proposed construction of a "loan" program provides a more dignified, and possibly cost-effective, alternative to Medicaid spend-down requirements.

Catastrophic Illness and the Non-Medicare Population

Concern over the problem of catastrophic illness among the Medicare population should not draw attention away from the significant problem of medical indigence in the non-Medicare population. Among the population not covered by Medicare, the major cause of catastrophic expense is acute medical care. Any significant illness is "catastrophic" for an individual without health insurance. Approximately 37 million Americans are without health insurance of any kind, and another 20 million are insured only intermittently, or have policies which do not cover catastrophic illnesses. When serious illness strikes these individuals, they become part of the medically indigent population.

Consequently, a major priority for both the public and private sector should be the implementation of methods to both reduce the number of uninsured and strengthen public programs to provide coverage for those individuals who are unable to purchase private health insurance. Appropriate actions include the strengthening of tax incentives to obtain adequate insurance, the creation of risk pools for the medically uninsurable, and the strengthening of Medicaid. Parallel actions should be taken to address the issue of catastrophic illness among the insured population. Insurers and employers should make information on the cost and potential value of catastrophic coverage more widely available, and federal policies should encourage the coverage of catastrophic illnesses by private insurance.

COMMENTS ON THE ADMINISTRATION'S PROPOSAL

We would also like to take this opportunity to provide some brief comments on the Administration's catastrophic proposal. The Medicare Catastrophic Illness Coverage Act (S.592) would: eliminate the day limitations on acute inpatient hospital care except for inpatient psychiatric hospital care; eliminate the confusing spell-of-illness concept and limit first-day hospital deductibles to two per year; eliminate all copayments for inpatient hospital and skilled nursing facility care; limit combined Part A and Part B cost-sharing for covered services to $2,000 per year; and fund these expanded benefits by adding an actuarially sound premium to the Part B premium, initially estimated to be $4.92 a month.

These proposed changes in the Medicare acute care benefit would be a first step in addressing the problem of catastrophic expenses for Medicare beneficiaries. Although there is only a small expansion of coverage, this and similar proposals would provide some relief to those beneficiaries who experience significant copayment and deductible expenses for covered services; some peace of mind for those beneficiaries frightened by the possibility of significant cost sharing for covered services; and simplification of the benefit and cost sharing provisions so that beneficiaries would be better able to assess the value of private Medicare supplemental insurance policies.

Although we urge adoption of a broader catastrophic approach, there are some modest expansions and alternative approaches that we believe would improve the extent to which S.592 deals with the acute care catastrophic needs of Medicare beneficiaries. They are: (1) better access to non-inpatient acute care services; (2) elimination of the lifetime limit on acute inpatient psychiatric hospital care; and (3) providing for income sensitivity in the financing of catastrophic coverage.

Expanding Access to Non-inpatient Care. As discussed in detail above, significant changes have occurred in methods for delivering acute care since the Medicare benefit package was originally designed. To be effective in responding to those changes, the Medicare acute care benefit should be revised to include outpatient pharmaceuticals (subject to an annual deductible and copayments) and to provide greater, more flexible use of home health and SNF services.

Eliminating the Limit on Acute Inpatient Psychiatric Care. The 190-day lifetime limit on acute inpatient psychiatric hospital care--which S.592 would leave intact--is outmoded and unnecessary. With extensive utilization controls and cost-per-case limits on payment, there is no basis for perpetuating a two-class system of coverage for psychiatric and non-psychiatric illness. It is inappropriate to substitute a limitation on benefits for effective utilization review, particularly given the active involvement of the psychiatric community in substantially improving utilization controls since Medicare was enacted.

In the past decade, there have been significant advances in psychopharmacology and biological testing that have resulted in more precise diagnoses and efficient approaches to treatment. There is also widespread and persistent evidence of the reduced rate of increase of medical expense following mental health treatment which argues for the inseparability of mind and body in health care. All public and private health insurance programs for financing health care should include benefits for the active treatment of mental illness and substance abuse and dependence that are equal to benefits provided for physical illness and disability.

Income Sensitivity in Financing Catastrophic Coverage. To generate revenues to support the expanded coverage, S.592 uses the straight-forward approach of an actuarially sound premium. This approach has the advantage of explicitly relating financing to the cost of beneficiary benefits. The primary disadvantage of a premium approach, of course, is that it is not income sensitive--an significant disadvantage for the 49 percent of the elderly whose annual incomes are less than $10,000. Furthermore, S.592 would provide the expanded coverage only to those Medicare beneficiaries who are enrolled in the Part B program. Although most beneficiaries are enrolled in both Parts A and B, almost 1 million beneficiaries are covered only by Part A and there is strong evidence to suggest that they may not be able to afford Part B coverage and are ineligible for Medicaid. A 1980 study showed that, for the most part, those with only Medicare coverage (unsupplemented by either Medicaid or private coverage) are those with the greatest medical needs and the fewest resources--people who are over 75, black, and have low income and education levels.

Although more complex, the idea of combining a universal premium with protections for low-income beneficiaries merits some examination. For example, Medicaid coverage could be restructured as an SSI supplemental package to cover copayments and pay the Medicare premium for those beneficiaries for whom even limited out-of-pocket payments would be a significant burden. For the low-income beneficiary who cannot afford supplemental insurance and who does not qualify for Medicaid coverage, counting premiums toward out-of-pocket limits and tying limits to income would be a major positive step.

CONCLUSION

Although discussions of the catastrophic care problem frequently focus on the dramatic, relatively rare, acute care expenses of the elderly, the catastrophic care problem is much broader and much deeper, extending to both young and old, uninsured and insured.

Many contend that we, as a nation, cannot afford to address all but a small portion of the problem. We submit that, as an enlightened society, we cannot afford to not address the full scope of the problem. The AHA pledges its support and cooperation in tackling this problem, building step by step toward a comprehensive approach to providing desperately needed relief for Americans from the fear of catastrophic illness and expense.

—from Senator Humphrey

QUESTIONS FOR OTIS R. BOWEN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

1. On February 5, 1987, you issued a memorandum to the Regional Health Administrators calling for scrupulous enforcement of longstanding department policies regarding Title X. You called for strict enforcement of both the Section 1008 abortion prohibition and the PHS Exceptional Organizations rules. Since, in 1982, the General Accounting Office clearly indicated that the Department needed to provide guidance regarding the policy interpretation of Section 1008 -- namely that Section 1008 prohibits Title X funds from being used to promote or encourage abortion--what actions have you taken since February 5 to provide the guidance needed regarding abortion related activities?

2. Jo Ann Gasper, Deputy Assistant Secretary for Population Affairs, issued a program instruction on January 21, 1987, which brought to the attention of the Regional Health Administrators that under the Exceptional Organization provisions of the department's rules, Regional Health Administrators were supposed to review organizations regarding their advocacy position. In your February 5, 1987, memorandum to the Regional Health Administrators, you agreed with this basic intention. It is my understanding that the Regional Health Administrators have not been reviewing organizations regarding their advocacy position -- contrary to PHS policy. What steps have you taken to insure that the RHA's review the organizations' advocacy position rather than just the projects?

3. The GAO (General Accounting Office) in 1982 pointed out areas where the Title X program was in violation of statute and department policy. These areas included:

* abortion counseling practices,

* abortion referral practices,

* the use of educational materials which link barrier methods of contraception with early abortion in case of contraceptive method failure,

* co-location of family planning clinics with abortion clinics to reduce the cost of providing abortion services, and

* the payment of quite large sums--in one case $27,000--out of the Title X program to organizations lobbying for abortion.

The Department of HHS responded to the GAO report by agreeing that guidance was necessary and would be forthcoming. It is my understanding that HHS has not issued the further guidance which you promised. Is thes correct? What guidance has been provided on these issues since 1982?

4. You wrote me on August 19, 1986, on the subject of a revision of the Title X guidelines, stating that:

> "Under the revised guidelines, counseling and referral for abortion will no longer be required except in cases in which this action is medically indicated because the life of the mother would be endangered if the pregnancy were carried to term. Grantees who wish to provide counseling and referral on all pregnancy option, including abortion, will still be permitted to do so when a woman with an unintended pregnancy makes an explicit request for information and/or referral, but such action will no longer be required."

On September 19, 1986, you again wrote to me on the subject of the revised guidelines, and said:

> "The words "are to" are being changed to "may", thus clarifying that counseling on the three options is not mandated when a woman with an unintended pregnancy requests information on her alternative courses of action. A copy of the guidelines and the new change are enclosed for your reference." (emphasis added)

It is my understanding that, in contradiction to the assurance offered in these letters, no guideline change has ever been issued. Is that correct? Why is this so?

5. Why is the department continuing to require abortion counseling for family planning purposes (i.e., to end an unintended pregnancy) when the Title X statute and longstanding HHS department policy clearly prohibit actions which promote or encourage abortion?

6. You have used the excuse that conference report language prohibits you from making administrative changes to Title X as a way of ensuring that the Title X program guidelines are not brought into conformance with longstanding department policy and the President's anti-abortion policy. Why is that? Does your department consider itself bound to conference report language? What is the basis for this determination?

7. When Congress enacted Title X, we clearly stated that programs where abortion is a method of family planning are not to be funded. Why have you permitted the Public Health Service to administrative countermand the intent of Congress and review only the "project"? "Project" is apparently defined by HHS as the activity for which Title X funds were provided, and since Title X funds can't be used for abortion, anything abortion-related is simply determined to be excluded from the project. (This is, I think, a tautology.) Will you go back to the language of the law, and exclude funding of Title X projects in programs where abortion is a method of family planning?

8. The co-location of abortion clinics with Title X family planning clinics clearly promotes abortion by cloaking abortion activities in the respectability of the family planning program. Co-location also reduces the cost of operating the abortion clinics and therefore represents an illegal subsidy of abortion. What actions have you taken, or will you take, to restrict the co-location of abortion clinics with family planning clinics?

9. I would like to commend you for your efforts in supporting the Administration's pro-life legislation. Clearly this initiative is important. We must not lose sight, however, that certain problems within the Title X program can be resolved administratively (i.e. review of advocacy organizations abortion counseling and referral, co-location of family planning and abortion clinics, restricting support of abortion lobbying). What steps are you taking to ensure that the Title X program is administered in strict conformance with the law and applicable rules and regulations since this has not been done in the past?

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

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Mr. James Powell
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Powell:

Enclosed are responses to the additional questions from the April 8 catastrophic health insurance hearing of the Labor and Human Resources Committee. Please excuse the delay in responding to your request.

Sincerely,

Trisha Knight

Patricia Knight
Deputy Assistant Secretary
for Legislation/Health

Enclosures

Question 1

On February 5, 1987, you issued a memorandum to the Regional Health Administrators calling for scrupulous enforcement of longstanding department policies regarding Title X. You called for strict enforcement of both the section 1008 abortion prohibition and the PHS Exceptional Organizations rules. Since, in 1982, the General Accounting Office clearly indicated that the Department needed to provide guidance regarding the policy interpretation of Section 1008 -- namely that Section 1008 prohibits Title X funds from being used to promote or encourage abortion -- what actions have you taken since February 5 to provide the guidance needed regarding abortion related activities?

Answer

Attached is a copy of the notice of proposed rulemaking which the Department published in the Federal Register on September 1, 1987. These proposed regulations will carry out President Reagan's pledge to strengthen and clarify rules which prohibit abortion or abortion-related activities in the Title X family planning program. The proposed regulations will:

- make clear that a project which provides counseling and referral for abortion services as a method of family planning will not be eligible for Title X funds;
- require Title X-supported projects to keep their projects entirely separate and distinct, financially and physically, from any abortion-related activities; and
- prohibit Title X projects from taking actions which encourage, promote or advocate abortion as a method of family planning, or which assist a woman in obtaining an abortion as a method of family planning.

Question 2

Jo Ann Gasper, Deputy Assistant Secretary for Population Affairs, issued a program instruction on January 21, 1987, which brought to the attention of the Regional Health Administrators that under the Exceptional Organization provisions of the Department's rules, Regional Health Administrators were supposed to review organizations regarding their advocacy position. In your February 5, 1987, memorandum to the Regional Health Administrators, you agreed with this basic intention. It is my understanding that the Regional Health Administrators have not been reviewing organizations regarding their advocacy position -- contrary to PHS policy. What steps have you taken to insure that the RHA's review the organizations' advocacy position rather than just the project?

Answer

While the Regional Health Administrators review all projects for compliance with Section 1008, clarification is needed on the exceptional organizations policy. Attached is a copy of a recent OIG letter to Senator Humphrey responding to several questions on the matter of exceptional organizations policy. In that letter, the OIG strongly recommends that the PHS Manual chapter be revised and re-issued (in the form of a regulation, if necessary) to clarify departmental policy regarding advocacy organizations and make the policy enforceable. The OIG further recommends that such a revision be undertaken by the Public Health Service (PHS) in conjunction with the Office of General Counsel (OGC) to ensure that the current legal vulnerabilities identified by OGC are fully addressed. This action is now being pursued by the Public Health Service.

Question 3

The GAO (General Accounting Office) in 1982 pointed out areas where the Title X program was in violation of statute and department policy. These areas included:

- abortion counseling practices,
- abortion referral practices,
- the use of educational materials which link barrier methods of contraception with early abortion in the case of contraceptive method failure,
- co-location of family planning clinics with abortion clinics to reduce the cost of providing abortion services, and
- the payment of quite large sums -- in one case $27,000 - out of the Title X program to organizations lobbying for abortion.

The Department responded to the GAO report by agreeing that guidance was necessary and would be forthcoming. It is my understanding that HHS has not issued the further guidance which you promised. It this correct? What guidance has been provided on these issues since 1982?

Answer

The September 1, 1987 proposed regulations will clarify rules which prohibit abortion or abortion-related activities in the Title X family planning program. The proposed regulations will require that a Title X-supported project provide an assurance satisfactory to the Secretary that it does not include abortion as a method family planning. The assurance must include representations as to compliance with specific requirements, including:

- A project which provides counseling and referral for abortion services as a method of family planning is not eligible to receive funds. In addition, since Title X funds are essentially intended for preventive family planning, services related to pregnancy care after pregnancy is diagnosed may not be provided with Title X funds.
- A project must be kept entirely separate and distinct, financially and physically, from any abortion-related activities. This requirement includes maintaining separate financial, accounting, personnel, and medical record systems and separately maintaining other project functions and physical facilities in such a manner as to clearly separate Title X funded activities from abortion-related activities.

Answer to Question 3 continued:

- A project may take no action which encourages, promotes or advocates abortion as a method of family planning, or which assists a woman in obtaining an abortion as a method of family planning. Lobbying for the passage of pro-abortion legislation, providing speakers to argue for abortion as a method of family planning, or paying dues to organizations that advocate abortion as a method of family planning are all prohibited activities under the proposed rules.

Question 4

You wrote me on August 19, 1986, on the subject of a revision of the Title X guidelines, stating that:

> "Under the revised guidelines, counseling and referral for abortion will no longer be required except in cases in which this action is medically indicated because the life of the mother would be endangered if the pregnancy were carried to term. Grantees who wish to provide counseling and referral on all pregnancy options, including abortion, will still be permitted to do so when a woman with an unintended pregnancy makes an explicit request for information and/or referral, but such action will no longer be required."

On September 19, 1986, you again wrote to me on the subject of the revised guidelines, and said:

> "The words "are to" are being changed to "may," thus clarifying that counseling on the three options is not mandated when a woman with an unintended pregnancy requests information on her alternative courses of action. A copy of the guidelines and the new change are enclosed for your reference." (emphasis added)

It is my understanding that, in contradiction to the assurance offered in these letters, no guideline change has ever been issued. Is that correct? Why is this so?

Answer

The Department's September 1, 1987 proposed rules for standards of compliance with the Title X statutory prohibition on use of appropriated funds in programs where abortion is a method of family planning would prohibit counseling and referral for abortion in all instances. Under the proposed rules, options counseling would no longer be permitted in Title X clinics. When the proposed regulations become final in December, they will supersede the present Title X guidelines to the extent that the guidelines are inconsistent with the final rules. After the final rules are issued, the Department intends to issue revised Title X guidelines reflecting the new regulatory standards.

Question 5

Why is the department continuing to require abortion counseling for family planning purposes (i.e., to end an unintended pregnancy) when the Title X statute and longstanding HHS department policy clearly prohibit actions which promote or encourage abortion?

Answer

The proposed rules will prohibit Title X projects from providing counseling and referrals for abortion. In order to give effect to the statutory prohibition on the use of Title X appropriated funds in projects where abortion is a method of family planning, under the proposed regulations, a project which provides counseling and referral for abortion services as a method of family planning will not be eligible for Title X funds.

Question 6

You have used the excuse that conference report language prohibits you from making administrative changes to Title X as a way of ensuring that the Title X program guidelines are not brought into conformance with longstanding department policy and the President's anti-abortion policy. Why is this? Does your department consider itself bound to conference report language? What is the basis for this determination?

Answer

The Department is not legally bound by conference report language and on September 1, 1987 published proposed rules to give effect to the statutory prohibition on the use of Title X funds in programs where abortion is a method of family planning.

Question 7

When Congress enacted Title X, we clearly stated that programs where abortion is a method of family planning are not to be funded. Why have you permitted the Public Health Service to administratively countermand the intent of Congress and review only the "project?" "Project" is apparently defined by HHS as the activity for which Title X funds were provided, and since Title X funds can't be used for abortion, anything abortion-related is simply determined to be excluded from the project. (This is, I think, a tautology.) Will you go back to the language of the law, and exclude funding of Title X projects in programs where abortion is a method of family planning?

Answer

Definitions clarifying the confusion over the terminology of "grantee," "organization," "program" and "project" are included in the September 1, 1987 proposed rules for the Title X family planning program.

The proposed regulation defines "grantee" as the organization to which a grant is awarded under section 1001 of the Public Health Service Act. "Organization," as applied to an applicant for or grantee of funds under Title X, means any public or private nonprofit entity in a State. An organization may operate multiple family planning or related program or projects. "Project" or "program," which are used interchangeably in the regulations, both refer to the identified activity approved for support under the Title X program, unless the context indicates otherwise. The proposed rules apply only to a Title X-funded "program" or "project": that is, "the identified activity approved by the granting agency for support." The proposed rules in no way purport to restrict an organization's activities in programs that are supported otherwise than by Title X funds. This limitation on the scope of the proposed rules reflects the express application of the section 1008 prohibition to "programs," and the statute's legislation history to the same effect.

Question 8

The co-location of abortion clinics with Title X family planning clinics clearly promotes abortion by cloaking abortion activities in the respectability of the family planning program. Co-location also reduces the cost of operating the abortion clinics and therefore represents an illegal subsidy of abortion. What action have you taken, or will your take, to restrict the co-location of abortion clinics with family planning clinics?

Answer

The September 1, 1987 notice of proposed rulemaking would require Title X-supported projects to keep their projects entirely separate and distinct, financially and physically, from any abortion-related activities.

Question 9

I would like to commend you for your efforts in supporting the Administration's pro-life legislation. Clearly, this initiative is important. We must not lose sight, however, that certain problems within the Title X Program can be resolved administratively (i.e., review of advocacy organizations, abortion counseling and referral, co-location of family planning and abortion clinics, restricting support of abortion lobbying). What steps are you taking to ensure conformance with the law and applicable rules and regulations since this has not been done in the past?

Answer

The September 1, 1987 notice of proposed rulemaking establishes standards for family planning services projects to comply with the statutory prohibition on the use of appropriated funds in programs where abortion is a method of family planning. These proposed regulations should improve compliance by grantees with the statute and facilitate monitoring of compliance. Specifically, the proposed regulations will:

- make clear that a project which provides counseling and referral for abortion services as a method of family planning will not be eligible for Title X funds;
- require Title X-supported projects to keep their projects entirely separate and distinct, financially and physically, from any abortion-related activities; and
- prohibit Title X projects from taking actions which encourage, promote or advocate abortion as a method of family planning, or which assist a woman in obtaining an abortion as a method of family planning.

federal register

Tuesday
September 1, 1987

Part V

Department of Health and Human Services

Public Health Service

42 CFR Part 59

Statutory Prohibition on Use of Appropriated Funds in Programs Where Abortion Is a Method of Family Planning; Standard of Compliance for Family Planning Services Projects; Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 59

Statutory Prohibition on Use of Appropriated Funds in Programs Where Abortion Is a Method of Family Planning; Standard of Compliance for Family Planning Services Projects

AGENCY: Public Health Service, DHHS.

ACTION: Proposed rules.

SUMMARY: The Public Health Service (PHS) proposes to amend the regulations governing the use of funds for family planning services under Title X of the Public Health Service Act in order to set specific standards for compliance with the statutory requirement that none of the funds appropriated under Title X may be used in programs where abortion is a method of family planning. This change is being proposed to bring the compliance requirements for programs using Title X funds into conformity with the statutory ban on such use of Title X appropriated funds. The proposed amendments should improve compliance by grantees with the statute and facilitate monitoring of compliance by PHS.

DATE: Comments must be in writing and be received by November 2, 1987. It is intended that final regulations will be promulgated within 45 days following the close of the above noted comment period.

ADDRESS: Comments should be sent to the Deputy Assistant Secretary for Population Affairs, Department of Health and Human Services, P.O. Box 23993, L'Enfant Plaza, Washington, DC 20026–3993.

FOR FURTHER INFORMATION CONTACT: Nabers Cabaniss at 202–245–0152.

SUPPLEMENTARY INFORMATION: On July 30, 1987, President Reagan announced that the Department of Health and Human Services would, within 30 days, publish draft regulations governing grants under Title X of the Public Health Service Act, 42 U.S.C. 300; *et seq.*, to give effect to the statutory prohibition on the use of Title X appropriated funds in programs that include abortion as a method of family planning. Set out below are the Department's proposed regulations, along with a statement of the basis and purpose of the amendments. The regulations proposed herein, when they become final, will automatically supersede the present Title X guidelines to the extent those guidelines are inconsistent with the final rules. After the final rules are issued, the Department intends to issue revised Title X guidelines in conformity therewith.

Background

Title X of the Public Health Service Act was enacted in 1970 by Pub. L. 91–572. Title X authorizes the Secretary of Health and Human Services to, among other things, make grants to public and private nonprofit entities "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services * * *." Section 1001(a) of the Public Health Service Act, 42 U.S.C. 300(a). Approximately 95% of the funds appropriated for Title X since enactment have been used to fund family planning service projects under section 1001(a). At present, 90 services grants are funded under section 1001(a); these grants fund the provision of voluntary family planning services at approximately 3,900 clinic sites.

Since enactment, Title X has contained the following prohibition at section 1008:

> [n]one of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

The legislative history of Title X in general, and of section 1008 in particular, reflects a fundamental dichotomy between the provision of preventive and other pre-pregnancy family planning services, on the one hand, and abortion on the other. As was stated in the Conference Report:

> [i]t is, and has been, the intent of both Houses that funds authorized under this legislation be used only to support preventive family planning services, population research, infertility services and other related medical, informational, and educational activities. The conferees have adopted the language contained in section 1008, which prohibits the use of such funds for abortion, in order to make clear this intent. Conf. Rep. No. 91–1667, 91st Cong., 2nd Sess. 8–9 (1970).

While the Conference Report reflects the conferees' understanding that certain "medical, informational and educational activities" are authorized under Title X, it is clear thet these activities must be "related" to "preventive family planning services, population research, and infertility services." *Id.* Actions that promote abortion are manifestly distinct from these activities. This distinction is emphasized by the explicit contrast between abortion and family planning drawn in the floor statement of Representative Dingell, the sponsor of section 1008, who stated:

> There is a fundamental difference between the prevention of conception and the destruction of developing human life. Responsible parenthood requires different attitudes toward human life once conceived than toward the employment of preventive contraceptive devices or methods. What is unplanned contraceptively does not necessarily become unwanted humanly . . . . 116 Cong. Rec. 37375 (1970).

In explaining the purpose of section 1008, Representative Dingell indicated in his floor statements that this provision was intended to prohibit more than the actual conduct of abortions. Rather—

> [w]ith the "prohibition of abortion" amendment—Title X, section 1008—the committee members clearly intend that abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act. 116 Cong. Rec. 37375 (1970).

He also observed that—

> [i]f there is any direct relationship between family planning and abortion, it would be this, that properly operated family planning programs should reduce the incidence of abortion. *Id.*[1]

Thus, it is clear that Title X is meant to fund the provision of preventive and other pre-pregnancy family planning services, and not to promote or encourage abortion in any way.

HHS's interpretation of these policies over the years, however, has not provided clear standards for grantees and HHS personnel. In 1982, the Department's Office of the Inspector General (OIG), after auditing 32 Title X clinics, found that the Department's failure to provide specific program guidance regarding the scope of section 1008 had created confusion about precisely what activities were proscribed by the section, and had resulted in variations in practice by grantees. In particular, the OIG audits found that the clinics were relying upon the Department's policy of permitting both Title X family planning services and separately funded abortion-related activities to be provided at a single site. Similar findings were noted by the General Accounting Office (GAO) in an audit of 14 Title X clinics, also conducted in 1982. GAO went on to recommend that "the Secretary establish clear operational guidance by incorporating into the Title X program regulations and guidelines, HHS' position on the scope of the abortion restriction in section 1008."[2] The President's July 30th directive to the Secretary was based in part upon this demonstrated need for changes in existing HHS program guidelines.

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[1] Regulations implementing section 1008 were initially issued in 1971 (36 FR 18465, Sept. 15, 1971) and revised in 1980 (45 FR 37436, June 3, 1980). In both cases, the regulations stated that Title X projects could not provide abortion as a method of family planning.

Accordingly, pursuant to its rulemaking power under 42 U.S.C. 300a–4(a), HHS has herein proposed to revise the regulations governing Title X so as to conform the obligations of grantees to the statutory prohibition in section 1008, and to establish standards for compliance with section 1008 that will permit adequate monitoring of such compliance. Providing Title X grantees with clear notice of specific compliance standards that give effect to the prohibition in section 1008 is necessary to improve compliance by grantees with section 1008 over the level that presently exists. At the same time, issuance of the proposed rules will strengthen the Department's ability to monitor compliance with section 1008 by providing a clearer basis for measuring grantee activities against objective requirements. Finally, the proposed rules will enable HHS to better enforce section 1008 by providing a basis in regulation for disallowance of costs or termination of program funding where noncompliance exists.

Provisions of the Proposed Rules

Title X authorizes grants for family planning programs. It further specifies that Title X funds may not be used in programs that include abortion as a method of family planning. The rules proposed below set out specific requirements intended to enforce this congressional mandate by making it clear that a Title X program is limited to providing family planning services, and may not provide abortion counseling and referral; that a Title X program must be entirely separate and distinct, financially and physically, from any abortion-related activities; and that a Title X program may not encourage, promote or advocate abortion as a method of family planning.

The proposed regulations, however, apply only to a Title X-funded "program" or "project": that is, "the identified activity approved by the granting agency for support." HHS Grants Administration Manual, Ch. 1–85–20. The proposed rules in no way purport to restrict an organization's activities in programs that are supported otherwise than by Title X funds. Definitions clarifying this terminology are included in the proposed rules. This limitation on the scope of the proposed rules reflects the express application of the section 1008 prohibition to "programs," and the statute's legislative history to the same effect. It is also consistent with existing case law holding that the government may favor normal childbirth by refusing to fund or promote abortion, but it may not preclude organizations whose programs receive government funds from using nongovernment resources in other programs that may include abortion-related activities. The proposed regulations accordingly are not to be construed as restricting or limiting the activities of grantee organizations when such activities are entirely outside of, and separate from, a Title X-funded program.

Certain provisions of the proposed rules derive directly from and strengthen the Department's longstanding practice in implementing section 1008. *See, e.g.,* proposed § 59.9 (relating in part to financial and accounting separation of abortion-related services from family planning programs) and proposed § 59.10 (relating in part to activities that encourage, promote or advocate abortion as a method of family planning by using legal action to make abortion available as a method of family planning, or by developing or distributing materials advocating abortion as a method of family planning). Since these rules represent no substantial change from prior practice, it would be most helpful if any comments in these areas contain suggestions for improvement based on prior operational experience with existing requirements.

Proposed § 59.7, requiring that programs seeking Title X funding provide an assurance that they will not include abortion as a method of family planning, is procedurally similar to a requirement that appeared in the Title X regulations until 1980. *See* 42 CFR 59.5(a)(9), as in effect from 1971 through 1980. New § 59.7, however, more closely tracks the language of section 1008, and incorporates more specific requirements designed in part to enable the Secretary to obtain at the application stage information relevant to determining whether a program will in fact comply with the statutory prohibition. If an applicant for Title X funds cannot demonstrate that it will comply with the statutory prohibition by conducting its family planning program consistent with the requirements of each of the proposed rules, it will not be eligible for Title X funds.

Proposed § 59.8 prohibits Title X projects from providing counseling and referrals for abortion. In the past, "mere referral" for abortion and nondirective counseling regarding abortion were not prohibited by the guidelines, on the theory that such activities do not promote or encourage the performance of abortion. Thus, the current Title X program guidelines require that whenever counseling for dealing with unintended pregnancy is requested, family planning clinics funded under Title X must provide "mere referral" and "nondirective" counseling on all options, including abortion, for dealing with the unintended pregnancy. As clearly contemplated by Title X and its legislative history, however, "family planning" is meant to address plans and methods for facilitating or preventing pregnancy, not for terminating it. As such, medical services or counseling related to pregnancy care after pregnancy diagnosis, or any services relating to abortion as a method of family planning, are outside the scope of activities supported by Title X funds.

Moreover, it is clear that counseling activity and other forms of information distribution were understood by Congress to be a significant part of the "family planning services" that Title X funds were to be used to fund. Thus, "mere referral" and counseling are clearly covered by the prohibition in section 1008 on abortion as a method of family planning.

In addition, it is unreasonable to assume that counseling and referrals for abortion do not indeed "encourage or promote" abortion. Specifically, the purpose of counseling programs for pregnant women is to provide information upon which they will base a course of action; counseling concerning abortion would be pointless in the absence of an expectation that some women receiving such counseling will choose to have an abortion. Similarly, providing a referral for abortion facilitates the obtaining of abortion, and the intended and actual effect of a referral program is that at least some women referred will select abortion as a method of family planning. Thus, even if abortion counseling and referral were not prohibited by the express language of section 1008 as family planning services that include abortion, the statutory purpose of section 1008 not to promote or encourage abortion would be better effectuated by proposed § 59.8.

In order, therefore, to conform program policies with the general statutory limitation on the use of Title X funds for "family planning services" and the specific prohibition in section 1008 on the use of Title X funds in programs where abortion is a method of family planning, as well as to better effectuate the statutory purpose of not promoting or encouraging abortion, proposed § 59.8 prohibits abortion counseling and referral, as well as medical services or counseling related to pregnancy care after pregnancy is diagnosed. One of the effects of these regulations will be to insure the ability of otherwise eligible organizations or programs that refuse to engage in abortion-related activities to receive support under Title X.

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[2] Comp. Gen. Rep. No. GAO/HRD–82–106, "Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification," p. 22 (1982) (hereafter referred to as the GAO Report).

Although proposed § 59.8 below prohibits counseling or referral for abortion, as well as counseling and other services relating to pregnancy that are provided after pregnancy diagnosis, it should be noted that the current Title X regulations provide, at § 59.5(b)(1), for "necessary referral to other medical facilities when medically indicated." Referrals to a comprehensive list of health-care providers who provide prenatal care and delivery are therefore permitted, provided that such referrals are not used as an indirect means to encourage or promote abortion. However—notwithstanding the Department's past view of this provision as requiring referrals for abortion in cases where it is medically indicated, such as where continuation of the pregnancy would endanger the life of the mother—it is the express purpose of the specific rule changes proposed below to insure that Title X-funded family planning project do not provide counseling or other services relating to the issue of "medical indication" for abortion. Rather, consistent with the legislative intent expressed in Title X—that is, the provision of preventive and other pre-pregnancy family planning services—§ 59.8 requires that pregnant women be referred outside of the Title X project for prenatal care and other related medical services. In no case, therefore, should a Title X-funded family planning program make a determination of the appropriateness of abortion.

Read together with proposed § 59.8, § 59.5(b)(1) will thus require referral in any case where pregnancy is diagnosed. Specifically, when a woman who is already pregnant comes to a Title X-funded family planning program, the program must provide her with a full listing of licensed health care providers of appropriate prenatal medical care and delivery services, from which she may select. This requirement is consistent with the legislative design of Title X as a program limited to funding preventive and other pre-pregnancy family planning services.

The Department solicits comments relating not only to proposed § 59.8, but also to its intended effect upon the meaning of § 59.5(b)(1). If necessary, the Department may amend the language in § 59.5(b)(1) in the final rules, in order to insure that the proposed change is unambiguous.

Proposed § 59.9 articulates new requirements designed to strengthen the Department's existing policy that abortion-related services must be "separate and distinct" from a Title X-funded program. Among these new requirements are provisions relating to the maintenance of separate medical records systems and the physical separation of a Title X project from any abortion-related functions or facilities.

The requirement of proposed § 59.9 that grantees maintain project medical record systems separate from any abortion-related operations is based squarely on the congressional intent that abortion not be a part of a Title X funded program. In this regard, the Department is concerned that commingled data systems may cause grantee organizations to aggregate abortion clients with Title X clients, and may inhibit monitoring of the segregation required by section 1008. The proposed rule thus seeks to ensure clearer records for purposes of excluding abortion-related activities from Title X funded programs and facilitating program monitoring. In fact, there is evidence that this requirement reflects the current practice of some grantees. The Department does not, therefore, anticipate that overall this requirement will impose substantial additional administrative burdens on grantees. See the GAO Report, p. 8.

The provisions of proposed § 59.9 relating to physical separation of abortion activities and family planning programs, while new, effectuate the underlying policy of section 1008. In the past, HHS has not consistently interpreted the statute so as to prohibit situations where the Title X project shares physical facilities (such as a common waiting or treatment area) with a project providing abortion services. HHS has now concluded, however, that a requirement of physical separation is necessary to strengthen the enforcement of the prohibition in section 1008.

In practice, an impermissible use of Title X funds may occur when the physical facility of a grantee organization's Title X-funded family planning program overlaps that of its abortion-related operations. Even where the strictest accounting and charging of expenses is performed, shared facilities inevitably increase the likelihood that a violation will occur, and lead to situations where the assertion that a program does not "include" abortion amounts to little more than an accounting fiction.

Accordingly, one purpose of proposed § 59.9 is to insure that Title X funds not be used for abortion-related activities. In addition, it is intended to further enforcement of the statutory requirement of section 1008 that abortion not be a method of family planning in a Title X program. Meeting this latter requirement mandates that Title X programs be organized so that they have an appropriate integrity and independence from other activities conducted by the grantee which are prohibited by statute from inclusion in a Title X funded program. Having a program that is separate and distinct from other such activities conducted by the grantee is a necessary predicate to any determination that abortion is not being included as a method of family planning in the program.

Moreover, proposed § 59.9 is independently justified by the need to prevent existing or potential clients of Title X projects—as well as the general public—from concluding that the government endorses abortion. By promoting the view that abortion is an acceptable and government-sanctioned method of family planning, moreover, the rendering of abortion and family planning services in common facilities violates the intent of Congress underlying section 1008, that Title X funds will not be used to "encourage or promote" abortion. Thus, proposed § 59.9 prohibits siting a Title X-supported family planning program in a fashion which would result in use of shared physical facilities—for example, with respect to waiting, consultation, examination, and treatment areas. It also prohibits Title X-funded projects from sharing office entrances and exits with an abortion facility. These proposed requirements effectuate the policy expressed in section 1008 that Title X projects not include abortion as a method of family planning.

One additional provision below—proposed § 59.10(a)(1) (relating to payment of dues to advocacy organizations)—constitutes a change from current program requirements. The provision of proposed § 59.10(a)(1) prohibiting payment of dues with project funds to advocacy organizations is necessary to ensure that Title X funds are not indirectly used to advance objectives that are not only inconsistent with Title X, but specifically prohibited by section 1008. Absent the restriction in proposed § 59.10(a)(1), neither the Department nor the grantee could ensure that Title X funds will not be used to encourage or promote abortion—activities which are prohibited by section 1008. See the GAO Report, pp. 24–26.

Regulatory Flexibility Act and Executive Order 12291

The proposed rules codify existing statutory requirements applicable to Title X grantees. With one exception, the effect of the proposed rules is to eliminate existing requirements or permissive provisions concerning the provision of abortion-related services, and as a result the proposed rules should to this extent produce a reduction in costs for Title X-funded programs. The exception is proposed § 59.9, relating to separation of abortion-related services from family planning programs. According to the Department's information, approximately 80 of the approximately 3,900 Title X-supported family planning sites are physically located near facilities that provide abortion services. Of these 80, it is unknown how many currently meet the requirements of proposed § 59.9. However, in view of the fact that the potential number of sites affected is small, and in view of the fact that current requirements under Title X already prohibit any direct subsidy of abortion services with Title X family planning funds, the Department believes it is unlikely that the proposed rule would have economic consequences even approaching the threshold for major economic consequences as defined in Executive Order 12291.

For the foregoing reasons, and consistent with the provisions of the Regulatory Flexibility Act (5 U.S.C. 605(b)), the Secretary also certifies that this rule will not have significant economic impact on a substantial number of small entities.

Paperwork Reduction Act

Proposed § 59.7 and proposed § 59.9 contain collection of information requirements which are subject to review by the Office of Management and Budget (OMB) under section 3504(h) of the Paperwork Reduction Act of 1980. 44 U.S.C. Chapter 35. The Department will submit an information collection request to OMB for its review.

Organizations and individuals desiring to submit comments on this information collection requirement should direct them to the agency official designated for this purpose whose name appears in the preamble and to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building (Room 3208), Washington, DC 20503, Attn.: Desk Officer for HHS.

List of Subjects in 42 CFR Part 59

Family planning—birth control, Grant programs—health, Health facilities.

Dated: August 28, 1987.

Robert E. Windom,
Assistant Secretary for Health.

Approved: August 28, 1987.

Otis R. Bowen,
Secretary.

For the reasons set out in the preamble, it is hereby proposed to amend Subpart A of Part 59, 42 Code of Federal Regulations, as set forth below.

PART 59—[AMENDED]

1. The authority citation for Subpart A of 42 CFR Part 59 is revised to read as follows:

Authority: 42 U.S.C. 300a–4.

2. In 42 CFR 59.2, the following definitions are added:

§ 59.2 [Amended]

"Family planning" means the process of establishing objectives for the number and spacing of a family's children, and selecting the means (including natural family planning methods, adoption, infertility services and general reproductive health care, abstinence and contraception) by which those objectives may be achieved. As such, family planning does not include medical services or counseling related to pregnancy care after pregnancy is diagnosed (including prenatal or post-partum care or counseling), or abortion-related services. As it relates to the statutory prohibition on the inclusion of abortion as a method of family planning, proper family planning should reduce the incidence of abortion.

"Grantee" means the organization to which a grant is awarded under section 1001 of the Public Health Service Act.

"Organization," as applied to an applicant for or grantee of funds under section 1001 of the Public Health Service Act, means any public or private nonprofit entity in a State. An organization may operate multiple family planning or related programs or projects.

"Program" and "project," which are used interchangeably in these regulations, both refer to the identified activity approved by the Secretary for support under section 1001 of the Public Health Service Act, unless the context indicates otherwise.

"Title X" means Title X of the Public Health Service Act, 42 U.S.C. 300, *et seq.*

§ 59.5 [Amended]

3. In 42 CFR 59.5, paragraph (a)(5) is removed and paragraphs (a)(6) through (a)(11) are redesignated as paragraphs (a)(5) through (a)(10) respectively.

§§ 59.7 through 59.13 [Redesignated as §§ 59.11 through 59.17]

4. In 42 CFR Part 59, §§ 59.7 through 59.13 are redesignated as §§ 59.11 through 59.17 respectively, and new §§ 59.7 through 59.10 are added to read as follows:

§ 59.7 Standards of compliance with prohibition on abortion.

A project may not receive funds under this subpart unless it provides assurance satisfactory to the Secretary that it does not include abortion as a method of family planning. Such assurance must include, at a minmum, representations (supported by documentary evidence, where the Secretary requests) as to compliance with each of the requirements in §§ 59.8 through 59.10. A project supported under this subpart must comply with such requirements at all times during the project period.

§ 59.8 Prohibition on counseling and referral for abortion services; limitation of program services to family planning.

(a) In order to give effect to the statutory prohibition on the use of Title X appropriated funds in projects where abortion is a method of family planning, a project which provides counseling and referral for abortion services as a method of family planning is not eligible to receive funds under this subpart. In addition, because Title X funds are intended only for family planning, services related to pregnancy care after pregnancy is diagnosed may not be provided with Title X funds. Where appropriate, medical or social service referrals for non-Title X supported services shall be made by providing a full list of available health care providers of appropriate prenatal medical care and delivery services and/or social service agencies from which a family planning client may select. Such referrals may not, however, be used as an indirect means to encourage or promote abortion in violation of section 1008, such as consciously weighting the list of referrals in favor of health care providers and/or facilities which provide abortions. One effect of these regulations will be to insure the ability of otherwise eligible organizations or programs that refuse to engage in abortion-related activities to receive support under this subpart.

(b) *Examples.* (1) A pregnant client at a family planning clinic supported with Title X funds solicits prenatal care services. Clinic personnel are medically qualified to provide such services. Nonetheless, provision of such services is outside the scope of family planning supported by Title X.

(2) A client at a family planning clinic supported with Title X funds seeks pregnancy testing and infertility counseling and services. Clinic personnel provide the requested services and in the process thereof discover an ectopic pregnancy. The client is immediately provided a complete list of appropriate hospitals and physicians from which to choose. This service is within the scope of family planning supported by Title X.

(3) A childless husband and wife seek counseling and services relating to infertility and adoption. Such counseling and services are within the scope of family planning supported by Title X.

(4) Clients at a family planning clinic are given a brochure and shown a film about birth control methods that include sections on abortion. Because use of the film and the brochure depicts abortion as a method of family planning, the clinic would not be eligible to receive Title X funds.

§ 59.9 Separation of abortion-related services from family planning programs.

(a) A project supported under this subpart must be kept entirely separate and distinct, financially and physically, from any abortion-related activities. This requirement includes maintaining separate financial, accounting, personnel, and medical record systems and separately maintaining other project functions and physical facilities (including office space, equipment, stationary and the like) in such a manner as to clearly separate Title X-funded activities from abortion-related activities. This requirement prohibits, by way of example, common waiting, consultation, examination, and treatment areas; shared telephone numbers and receptionists; common names for eligible and ineligible programs; and common office entrances and exits. Although common street or mailing addresses will presumptively constitute a failure to separate adequately Title X-funded programs from other programs which include abortion as a method of family planning, grant applicants may seek to establish the reasonableness of such arrangements in exceptional cases where, as in the example of a large metropolitan hospital with abortion and family planning services located in different wings, the fact of physical separation is otherwise established and no use of appropriated funds in an ineligible program is likely.

(b) *Examples.* (1) A nonprofit family planning organization operates abortion and family planning clinics simultaneously on Wednesdays and Fridays in the same one-story building. Nothing on the exterior of the building indicates the existence of two separate programs, although the programs are organized as legally separate entities. The clinics utilize a common parking lot adjacent to the building, a common entrance at the front of the building, and a common receptionist and reception area. The two clinics share the same executive director and financial manager, and the abortion clinic pays a management fee for the services of such personnel. Two other employees of the family planning clinic also work for the abortion clinic. The family planning clinic refers clients to the abortion clinic. The family planning clinic in this example is not "separate and distinct, financially and physically," from abortion-related activities.

(2) A nonprofit organization operates both abortion and family planning clinics at the same address. Both clinics are staffed by the same personnel, and the medical director for the family planning program generally performs the abortions for the abortion clinic as well. The programs, however, schedule clients at different times, with abortion clinic hours only in the mornings and family planning hours only in the afternoon. The schedules do not overlap. The programs use the same telephone number, and the same receptionist answers the phone and makes appointments for both. The programs use the same automobiles, office furnishings, and advertisements. The family planning program in this example is not "separate and distinct, financially and physically," from abortion-related activities.

(3) A private, nonprofit corporation operates a family planning program (Program A) and a program which includes abortion-related services (Program B). Both programs are operated as parts of the same corporate entity, with common directors and officers. Program A and Program B occupy office space leased under the terms of a common master lease, but the offices are in fact located in different sections of the city. Program A maintains entirely separate financial records and has no on-site personnel in common with Program B. The programs conduct no joint advertising and use separate furnishings and equipment. Program A is "separate and distinct, physically and financially," from Program B.

(4) A private, nonprofit organization operates both a family planning clinic that receives Title X funds and an abortion clinic. The clinics are physically separate, but their accounting and financial records are maintained jointly. Although the family planning clinic is separated physically from the abortion clinic, the joint financial records indicate that the family planning clinic is not "separate and distinct, financially and physically" from abortion-related activities.

(5) A private, nonprofit organization operates both a family planning clinic and an abortion clinic. Both clinics lease space in the same one-story building. The two clinics share a common waiting room. The family planning clinic has separate personnel and maintains separate financial records from the abortion clinic. The family planning clinic in this example is not "separate and distinct, physically and financially" from the abortion-related activities.

§ 59.10 Prohibition on activities that encourage, promote or advocate abortion.

(a) A project supported under this subpart may take no action which encourages, promotes, or advocates abortion as a method of family planning, or which assists a woman in obtaining an abortion as a method of family planning. Actions are considered to encourage, promote, or advocate abortion as a method of family planning if they in any way have the effect of facilitating obtaining abortion as a method of family planning. Such prohibited actions include the following:

(1) Lobbying for the passage of pro-abortion legislation, providing speakers to argue for abortion as a method of family planning, or paying dues to organizations that advocate abortion as a method of family planning;

(2) Using legal action to make available in any way abortion as a method of family planning;

(3) Developing, assisting in the development of, posting or disseminating in any way materials (including printed matter and audio-visual materials) that advocate abortion as a method of family planning;

(b) *Examples.* (1) A family planning clinic provides those of its clients who inquire concerning abortion with brochures advertising an abortion clinic. Such a service would "encourage, promote or advocate" abortion.

(2) A family planning clinic pay dues to an organization that devotes a substantial part of its activities to lobbying the Congress for liberalized abortion laws. This activity would "encourage, promote or advocate" abortion.

(3) A family planning clinic displays in its waiting room posters encouraging clients to write their legislative representatives to urge them to vote "pro choice" on pending legislation, and

distributes post cards for the same purpose. The clinic is engaged in "encouraging, promoting or advocating" abortion.

(4) A family planning clinic that receives Title X funds assists its clients in making appointments at abortion clinics. The provision of such services would violate section 1008.

(5) Personnel of a family planning project write their legislative representatives in support of pro-choice legislation, utilizing no project funds to do so. The eligibility of the project for Title X funds would be unaffected by their advocacy of abortion.

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DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

AUG 12 1987

The Honorable Gordon J. Humphrey
United States Senate
Washington, D.C. 20510

Dear Senator Humphrey:

This is in response to your letter of July 7, 1987, concerning the Department's extension of training grants under title X of the Public Health Service (PHS) Act to Planned Parenthood of Wisconsin and Planned Parenthood Federation of America. More specifically, you requested that this office review the award of grant funds to these two organizations, "to determine if the action was consistent with the law and Department policy and regulations, especially regarding 'exceptional organizations.'" You further asked that we respond to nine questions concerning the grant awards.

This office has reviewed voluminous records pertaining to the grant awards in question. For the reasons set forth below, we have found that there are inconsistencies and other serious flaws and weaknesses in the PHS policy pertaining to advocacy organizations, and are recommending that they be revised, clarified and strengthened. Further, given the problems with the policy, the General Counsel's office concluded that this policy could not successfully be relied upon as a basis for withholding the grant extensions. Therefore, it appears that the Department's action in extending these grant awards did not give rise to an actionable violation of governing law. Following is a discussion of the bases for these conclusions.

In response to your inquiry, this office reviewed grant documents and audit records pertaining to the two grantees and their compliance with the abortion prohibition of title X. This review disclosed that Planned Parenthood of Wisconsin was among 32 title X grantees specifically audited by the Office of Inspector General (OIG) in 1982. That audit failed to disclose any instance in which the grantee had violated the abortion restriction of title X. The OIG audit also did not find that this grantee had engaged in unlawful lobbying (for abortion or otherwise) using Federal funds. Any such activity was supported using nonfederal funds. Further, our review of audit reports prepared by certified public accounting firms

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which audited Planned Parenthood of Wisconsin and the Planned Parenthood Federation of America identified no deficiencies in financial or program management. For your information, a copy of the OIG audit and a related audit conducted by the General Accounting Office (in which GAO reached the same conclusions as did we) are enclosed. In addition, we have enclosed for your review the grant award documents, financial status reports and certified public accountants' reports for the two grantees (Enclosure 1).

Because the Inspector General is barred by law from exercising program operating responsibilities (42 U.S.C. 3526(a)), and because your request poses questions calling for legal and policy determinations, we were compelled to discuss the issues you raised with program officials of the Public Health Service (PHS) and with the Office of General Counsel (OGC). The General Counsel provided us a legal opinion which had been prepared at his request for the purpose of addressing the legal issues pertaining to the extension of the grant awards to the two Planned Parenthood affiliates. With the concurrence of the General Counsel, we have enclosed their memorandum (Enclosure 2).

Very briefly, the OGC opinion concludes that a refusal to extend grant awards based solely on an undocumented assessment that the prospective grantees were advocacy organizations under Chapter 700 of the PHS Grants Administration Manual would be subject to attack on a number of diverse legal grounds, and would likely not survive judicial review. Among the legal problems identified by the General Counsel are: (1) the interpretation of Chapter 700 proposed by the Office of Population Affairs is at odds with the statutory abortion prohibition of title X which does not prohibit grantees from engaging in abortion-related activities so long as they do so entirely with nonfederal funds and in a program that is entirely separate from the title X-funded project; (2) the PHS Manual provisions themselves do not clearly authorize denial or delay of grant awards prior to a review of the grantee's application and a determination that it is an advocacy organization; (3) a refusal to award a grant based exclusively on the grantee's privately funded conduct raises constitutional questions under the recent Supreme Court case of Babbitt v. Planned Parenthood; (4) without underlying evidence of violations of title X by the grantees in question, and given their successful completion of a 3-year grant cycle, it is likely that a court would find the Department's refusal to extend the grants arbitrary and capricious; and (5) the Manual was never promulgated as a formal rule and therefore is not enforceable against the Department. This office has found no basis to disagree with the legal conclusions of the OGC.

FINDINGS

Applying the opinion of the OGC, we found that there are serious ambiguities in the Manual provisions concerning advocacy organizations, and with application of those provisions so as to deny funding to prospective grantees. Because of these and other vulnerabilities, the PHS Manual chapter should be revised and re-issued so as to clarify PHS policy regarding advocacy organizations and make the policy enforceable. In addition to the legal problems discussed above, our review of Chapter 700 has disclosed various internal inconsistencies and deficiencies that should be clarified in the revised policy on advocacy organizations. These include:

- There is an apparent contradiction in Chapter 700 concerning the ability of PHS to deny grant awards to advocacy organizations. Section 700.7(a) states that the advocacy organizations provision "is not intended to limit in any way the eligibility of advocacy organizations to receive grants nor to allow approval or disapproval of the goals of the advocacy organization to affect the PHS agency's decision whether or not to award the grant." However, at section 700.7(b)(3), the same Chapter states that where "an organization's commitment to its own goals involves the strong likelihood that grant funds may be misused . . . the option of not awarding the grant should be carefully considered." The revised policy should reconcile these two seemingly inconsistent provisions.[1]

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[1] It should be noted that the departmentwide grant policy, as expressed in Chapter 1-05 of the Grants Administration Manual, also addresses grants to advocacy organizations. However, this guidance is fairly general, in that it requires only that the head of a granting agency notify the Executive Secretary of grants to high-risk advocacy organizations. Thus, the PHS Manual currently goes beyond departmentwide policy. The relevant section of the Department's Manual is enclosed for your review (Enclosure 3).

- Section 700.7(b) of the PHS Manual currently sets forth various risks associated with awarding grants to advocacy organizations. The Manual, however, provides no guidance as to the kinds of facts that would be considered evidence of unacceptable advocacy; not merely its potential risks. As a result, PHS grant officials, grant applicants and auditors have no clear criteria to determine whether a potential grantee is an advocacy organization.

- Section 700.7(b) of the Manual entitled "General Considerations," states that in making awards to advocacy organizations, the awarding agency should.take "special care," and should "incorporate appropriate controls, and provide for close monitoring of the grantee." However, the Manual does not adequately specify those actions available to the granting office when it identifies an applicant as an advocacy organization. Such guidance is necessary to ensure consistent, effective application of the policy.

The nine specific questions you posed largely call for legal interpretations of rules pertaining to the Department's programs and, as such, are addressed at length in the legal opinion and other materials accompanying this letter. However, we do have a comment on your questions as to whether the two training grantees qualify as "advocacy organizations" under Chapter 700 of the PHS Manual. As written, that chapter provides insufficient criteria for determining whether an applicant meets the definition of advocacy organizations. Therefore, as noted above, our recommendations, in part, call upon PHS to revise their Manual to provide clear standards for identifying such organizations. The need for clarification in this particular context is consistent with the more general finding contained in the 1982 OIG audit report that there was a need for more explicit guidelines to define the scope of prohibited abortion-related activities.

RECOMMENDATIONS

On the basis of the findings listed above, we are strongly recommending that the PHS Manual chapter be revised and re-issued (in the form of a regulation, if necessary) so as to clarify departmental policy regarding advocacy organizations and make the policy enforceable. Such a revision should be undertaken by PHS in conjunction with

OGC to ensure that the current legal vulnerabilities identified by OGC are fully addressed. The revised policy should also accomplish the following:

- The contradiction contained in the current policy as to whether a prospective grantee's status as an advocacy organization may be grounds for denying a grant award should be eliminated. Any revision in this regard should be reviewed by OGC to ensure that it is constitutional in light of Babbitt.
- The revised policy should clearly stipulate what kinds of facts would be considered evidence of unacceptable advocacy. Such guidelines would provide needed criteria for both PHS grants officials and grant applicants to determine whether a potential grantee is an advocacy organization requiring special attention. These standards would also furnish criteria for auditors and other Department officials to use in reviewing determinations made under the policy.
- The revised policy should state clearly the actions that are available to the granting office when it identifies a grant applicant as an advocacy organization. The options could include delaying the award pending implementation of specified safeguards by the grantee, or making the award but providing for technical assistance or special reporting by the grantee. Although the determination of whether an organization is an advocacy organization under Chapter 700 should not be delayed until a grant award is imminent, PHS should consider including specific authorization for a short term-extension of existing grants where necessary to obtain information with respect to advocacy activities.

A memorandum containing all of our recommendations will be sent to the Assistant Secretary for Health in the near future. We will, of course, provide you with a copy of that memorandum when it is prepared.

CONCLUSION

In summary, based in large measure on the legal conclusions of the OGC, with which we have found no independent basis to disagree, the action of the

Department in extending these two grants does not appear to have been in violation of governing law. However, in order to avoid confusion in the future over the scope and application of the PHS policy with respect to advocacy organizations, we are recommending that that policy be clarified and made enforceable. Specifically, the revised Manual should provide criteria to ensure that advocacy organizations are identified, and that the Department has available appropriate and enforceable preventive and remedial actions to fully safeguard the Department's interests under the applicable grant program.

A final note. As you know, on July 30, 1987 President Reagan directed the Department to publish revised regulations to better describe the scope of the abortion prohibition of title X. These revised regulations will, in part, set standards restricting advocacy activities by title X grantees. In addition, the rules will prohibit grantees from providing counseling and referral for abortion services, and will require grantees to segregate any abortion-related services from the title X supported project. The President directed that these rules be published within 30 days, so they will be published shortly. You are likely to find that the revised rules will address some of the same policy concerns that appear to underlie the questions posed in your letter.

We hope that the above information and enclosed materials are responsive to your needs. Should you have any additional questions, please do not hesitate to contact me.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosures

Senator Cochran

QUESTION: Mr. Secretary, what is your reaction to the argument I have heard that your proposal will unfairly supplant insurance coverage that is now being offered by private insurance companies?

ANSWER: Senator Cochran, I believe that the Medigap or insurance industry would not be "destroyed" or totally replaced, as some have charged. As I mentioned in my remarks, it is probable that insurors would have to rewrite or adjust some of their policies, but there still will be a vast market for them. For example, there would be a market for the $2,000 cap, or for things that Medicare does not presently cover, such as prescription drugs or dental care.

In addition, the debate on the catastrophic insurance proposal has opened up an excellent dialogue on the long-term care issue. It seems to me that the gates would be wide-open for long-term care insurance.

Senator ADAMS. The Committee will stand in recess.

[Whereupon, at 1:29 p.m., the Committee was adjourned.]

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